CHAPTER 63
LONG-TERM CARE SERVICES

SUBCHAPTER 1 GENERAL PROVISIONS

10:63-1.1 Scope

This chapter addresses the provision of quality, cost-prudent health care services available to New Jersey Medicaid eligible children and adults in a nursing facility (NF) and addresses the provision of and reimbursement for services required to meet the individual's medical, nursing, rehabilitative and psychosocial needs to attain and maintain the highest practicable mental and physical functional status. Although the scope of the Long-Term Care Services chapter encompasses other long-term care facilities such as governmental psychiatric hospitals, inpatient psychiatric services/programs for the under 21 (residential treatment centers) and intermediate care facilities/mentally retarded (ICF/MRs), the following subchapters specifically address nursing facility services. However, the Fiscal Agent Billing Supplement applies to all the above cited long-term care facilities.

10:63-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Advance directive" means a written instruction relating to the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney for health care.

"Air fluidized therapy bed" means a device employing the circulation of filtered air through ceramic spherules (small, round ceramic objects).

"Case management" means a process by which the Division of Medical Assistance and Health Services Medical Social Care Specialist monitors the provision of nursing facility care to assure timely and appropriate provider responses to changes in care needs and delivery of coordinated services.

"Case mix" means a system of staffing and reimbursement for nursing services based on variation in patient acuity and care needs that influences the type and amount of service needed.

"Clinical audits" means a method of utilization control under the enforcement authority of Section 1902(a)(30)(A) of the Social Security Act, in accordance with 42 CFR 456.1(b)(1), to monitor the utilization of and payment for nursing facility care and services reimbursable under the Medicaid State Plan.

"Comprehensive assessment" means a process conducted by each member of the interdisciplinary team which, for each resident, identifies problems; determines care needs; and in conjunction with the resident and his or her significant other or legal representative, results in an interdisciplinary plan of care.

"Consultant pharmacist" means a pharmacist licensed by the New Jersey State Board of Pharmacy who meets the qualifications in N.J.A.C. 10:51-3.3.

"Conventional nursing facility"-see nursing facility.

"Department of Health" (DOH) means the New Jersey State Department of Health.

"Division of Developmental Disabilities (DDD)" means the Division of Developmental Disabilities within the New Jersey State Department of Human Services.

"Division of Mental Health and Hospitals (DMH & H)" means the Division of Mental Health and Hospitals within the New Jersey State Department of Human Services.

"Health Services Delivery Plan (HSDP)" means an initial plan of care prepared by the Regional Staff Nurse during the Pre-Admission Screening (PAS) assessment process which reflects the individual's current or potential health problems and required care needs.

"Interdisciplinary care plan" means the care plan developed by the interdisciplinary team which includes measurable objectives and time tables to meet the resident's medical, nursing, dietary and psychosocial needs that are identified through the comprehensive assessment process.

"Interdisciplinary team" means a team consisting of a physician and a registered professional nurse and may also include other health professions relative to the provision of needed services. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

"Low airloss therapy bed" means a bed frame that is equipped with air sacs which are grouped into zones corresponding to various body areas. The air sacs are inflated by a constant flow of air, some of which is directed through the air sacs to the patient surface.

"Medicaid occupancy level" means the average number of Medicaid recipients and recipients of public assistance under P.L.1947, c. 156, as amended (C44.8-107 et seq.) residing in a NF divided by the total number of licensed beds in the facility during the billing month.

"Medical director" means a physician licensed under New Jersey State law who is responsible for the direction and coordination of medical care in a nursing facility.

"Medical evaluation team (MET)" means a team of Medicaid professionals consisting of a physician consultant, a regional staff nurse (RSN), a regional pharmaceutical consultant, a Medical Social Care Specialist I (MSCS I) and a Medical Social Care Specialist II (MSCS II) who are assigned to the Medicaid District Office (MDO). A MET has the responsibility to review medical, nursing, and social information as well as any other supporting data in order to evaluate the need for long-term care, determine the level of care needed, the feasibility of alternate care, the quality of care given and the outcome of service. Members of the MET may review each recipient or potential recipient as individual team members or may perform the review as a multidisciplinary team.

"Medical social care specialist (MSCS)" means a social worker employed by the Division of Medical Assistance and Health Services who performs case management as required by N.J.A.C. 10:63.

"Medical staff" means one or more licensed physicians who act as the attending physician(s) to Medicaid recipients in a nursing facility.

"Minimum data set (MDS)" means a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing facility resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

"New nursing facility" means a facility which satisfies the following criteria:

1. Does not replace a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;
2. Does not assume the per diem rate of a pre-existing facility; and
3. Does not have a specific pre-existing patient base.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health for participation in Title XIX Medicaid and primarily engaged in providing health-related care and services on a 24-hour basis to Medicaid recipients (children and adults) who, due to medical disorders, developmental disabilities and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. However, the nursing facility is not primarily for care and treatment of mental diseases which require continuous 24-hour supervision by qualified mental health professionals

or the provision of parenting needs related to growth and development.

"Occupational therapist" means a person who is registered by the American Occupational Therapy Association, 1383 Piccard Drive, P.O. Box 1725, Rockville, MD 20849-1725, or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

"Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association, 515 N. State St., Chicago, IL 60610, and the American Physical Therapy Association, 1111 N. Fairfax St., Alexandria, VA 22314 or its equivalent; and if practicing in the State of New Jersey, is licensed by the State of New Jersey, or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable, and also meets all applicable Federal requirements.

"Physician's services" means those services provided within the scope of medical practice as defined by the laws of New Jersey and those services which are performed by or under the direct personal supervision of the physician.

1. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.
2. "Direct personal supervision" means services which are rendered in the physician's presence.

"Pre-admission screening (PAS)" means that process by which all Medicaid eligible recipients seeking admission to a Medicaid certified NF and individuals who may become Medicaid eligible within six months following admission to a Medicaid certified NF receive a comprehensive needs assessment by the Regional Staff Nurse to determine their long-term care needs and the most appropriate setting for those needs to be met, pursuant to N.J.S.A. 30:4D-17.10. (P.L.1988, c. 97).

"Pre-admission screening and annual resident review (PASARR)" means that process by which all individuals with mental illness (MI) or mental retardation (MR) are screened prior to admission to a NF and annually thereafter in order to determine the individual's appropriateness for NF services, and whether the individual requires specialized services for his or her condition.

"Prior authorization" means approval granted by the Division of Medical Assistance and Health Services through the appropriate Medicaid District Office

(MDO) for payment for NF or before other Medicaid covered services are rendered to a Medicaid recipient, in accordance with this chapter.

"Regional staff nurse (RSN)" means a registered professional nurse employed by the Division of Medical Assistance and Health Services who performs health needs assessments as required by this chapter.

"Rehabilitative and/or restorative nursing care" means nursing care provided by a registered professional nurse, or under the direction of a registered professional nurse, qualified by experience in rehabilitative or restorative nursing care.

"Rehabilitative services" means physical therapy, occupational therapy, speech-language pathology services, and the use of such supplies and equipment as are necessary in the provision of such services.

"Replacement nursing facility" means a facility which satisfies the following criteria:

1. Replaces a pre-existing facility which was licensed in accordance with N.J.A.C. 8:39;
2. Can assume the per diem rate of the pre-existing facility; and
3. Has a specific pre-existing patient base.

"Resident" means a Medicaid eligible or potentially eligible recipient residing in an NF.

"Respiratory care practitioner" means an individual credentialed by the State Board of Respiratory Care, to practice respiratory care under the direction or supervision of a physician pursuant to State of New Jersey P.L.1971, c. 60; P.L.1974, c. 46; and P.L.1978, c. 73, amended August 1991.

"Section Q" means the resident classification portion of the standardized resident assessment (SRA) instrument which identifies an individual NF resident's nursing service requirements based on the standards at N.J.A.C. 10:63-2.2(a).

"Skilled nursing facility (SNF)" means a free-standing institution or an identifiable part of an institution which meets all the State and Federal requirements for participation in the Medicare Program as a skilled nursing facility.

"Social services" means those services provided to meet the emotional and social needs of the Medicaid recipient and significant other or guardian at the time of admission, during treatment and care in the facility, and at the time of discharge.

"Special care nursing facility (SCNF)" means a NF or separate and distinct unit

within a Medicaid certified conventional NF which has been approved by the Division of Medical Assistance and Health Services to provide care to New Jersey Medicaid recipients who require specialized health care services beyond the scope of conventional nursing facility services as defined in N.J.A.C. 10:63-2, Nursing Facility Services.

"Specialized services for mental illness (MI)" mean those services offered, in accordance with 42 CFR 483.120, when an individual is experiencing an acute episode of serious mental illness and psychiatric hospitalization is recommended, based on a Psychiatric Evaluation. Specialized Services entail implementation of a continuous, aggressive, and individualized treatment plan by an interdisciplinary team of qualified and trained mental health personnel. During a period of 24-hour supervision for the individual, specific therapies and activities are prescribed, with the following objectives: to diagnose and reduce behavioral symptoms; to improve independent functioning; and as early as possible, to permit functioning at a level where less than specialized services are appropriate. Specialized services go beyond the range of services which a NF is required to provide.

"Specialized services for mental retardation (MR)" mean those services offered, in accordance with 42 CFR 483.120, when an individual is determined to have skill deficits or other specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the individual functional skills. Specialized services are those services needed to address such skill deficits or specialized training needs. Specialized services may be provided in an intermediate care facility for the mentally retarded (ICF/MR) or in a community-based setting which meets ICF/MR standards. Specialized services go beyond the range of services which a NF is required to provide.

"Speech-language pathologist" means a person who has a certificate of clinical competence from the American Speech and Hearing Association; meets all applicable Federal regulations; has completed the equivalent educational requirements and work experience necessary for the certificate, or has completed the academic program and is acquiring supervised work experience to qualify for the certificate, and, if practicing in the State of New Jersey is licensed by the State of New Jersey; or if treatment and/or services are provided in a state other than New Jersey, meets the requirements of that state, including licensure, if applicable.

"Standardized Resident Assessment (SRA)" means an instrument developed by the State to report minimum data set requirements, including resident assessment protocols and additional State mandated data, which results in a comprehensive, standardized assessment of a NF resident's functional capabilities and service requirements.

"Track of care" means the designation of the setting and scope of Medicaid

services determined by the PAS process conducted by the RSN following assessment of the Medicaid eligible or potentially eligible Medicaid recipient, as follows:

1. "Track I" means long-term NF care.
2. "Track II" means short-term NF care.
3. "Track III" means long-term care services in a community setting.

"Transfer of ownership" means, for reimbursement purposes, a change in the majority ownership that does not involve related parties, related corporations or public corporations. "Majority ownership" is defined as an individual or entity who owns more than 50 percent of the facility.

"Waiting list" means the standardized listing, maintained in chronological order by the NF, of the names of all individuals seeking admission to a Medicaid participating NF who have completed a written application.

10:63-1.3 Program participation

(a) A NF shall comply with the following requirements in order to be eligible to participate in the New Jersey Medicaid program. An in-State NF shall:

1. Be licensed by the New Jersey Department of Health and Senior Services in accordance with N.J.A.C. 8:39;
2. Be certified by the New Jersey Department of Health and Senior Services, and in the case of both Medicare and Medicaid, by the Health Care Financing Administration (HCFA), which assures that the NF meets the federal requirements for participation in Medicaid and Medicare;
3. Be approved for participation as a NF provider by the New Jersey Medicaid program. This includes the filing of a New Jersey Medicaid Provider Application FD-20 (see Appendix A, incorporated herein by reference), the signing of a Provider Agreement MCNH-38 (see Appendix B, incorporated herein by reference), and submittal of the HCFA-1513, Ownership and Control Interest Disclosure Statement (see Appendix C, incorporated herein by reference). The agreement for participation in the New Jersey Medicaid program stipulates that a NF shall provide all NF services required by N.J.A.C. 10:63. Continued participation as a New Jersey Medicaid provider will be subject to recertification by the New Jersey Department of Health and compliance with all Federal and State laws, rules and regulations. Upon recertification by the Department of Health, each NF will receive notification from the

Provider Enrollment Unit, Division of Medical Assistance and Health Services, informing the facility that their provider agreement is being continued.

4. File a completed Cost Study for Long-Term Care Facility form MCNH-1 (see Appendix D, incorporated herein by reference) with the New Jersey State Department of Health and the Division of Medical Assistance and Health Services. After the initial cost study is filed, the provider shall file an MCNH-1 annually.

5. In accordance with 42 C.F.R. 483.12(d)(1)(i)(ii), not require residents or potential residents to waive their rights to Medicare or Medicaid; and not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for Medicare or Medicaid benefits;

6. Accept as payment in full for covered services, the amounts paid in accordance with Medicaid policy defined at N.J.A.C. 10:49-9.3(a)2; and

7. Except as provided in (a)7i below, by December 1, 1997, be certified by Medicare as a provider of skilled nursing services for no less than seven percent of the facility's total licensed long-term care beds.

   i. This requirement shall not apply if a nursing facility cannot be certified as a Medicare skilled nursing 63-4.1Supp. 4-6-98

   ii. Upon receipt of the application, the Department of Health and Senior Services shall determine whether the facility shall be recommended for Medicare certification in accordance with 42 C.F.R. 483. If the facility cannot be certified for Medicare participation, the Department shall provide the facility with the reasons for the certification denial in writing.

10:63-1.4 Private pay

(a) NFs which are approved for participation as providers of services under the New Jersey Medicaid program shall be prohibited under Section 6(a) of P.L.1985, c. 303 from soliciting or accepting payment, any type of gift, money, contribution, donation or other consideration as a condition of admission or continued stay from a Medicaid recipient or his or her family.

(b) NFs which are providers of service under the New Jersey Medicaid program shall be prohibited under Section 6(b)(c) of P.L.1985, c. 303 from requiring private pay contracts from Medicaid qualified applicants as a condition for admission or continued stay.

1. The prohibitions in (a) and (b) above are applicable regardless of the Medicaid occupancy level in a facility. A violation may be a criminal act punishable as a crime of the third degree.

2. The exception to the above is private pay contracts entered into with life-care communities that are explicitly referenced as such within their Medicaid participation agreement.

(c) An individual may enter a NF on a private pay contract basis only if Medicaid eligibility has not been established and no application to the New Jersey Medicaid program has been made. A private pay contract shall become void as soon as Medicaid eligibility is established.

10:63-1.5 Occupancy level

(a) The NF Medicaid occupancy level shall be calculated by adding the total days for Medicaid and public assistance recipients residing in the NF during the month, dividing this sum by the number of days in the month to determine the average daily census, and dividing this amount by the total number of licensed long-term care beds.

1. A Special Care Nursing Facility (SCNF) which is an identifiable unit within a conventional NF shall calculate its occupancy level separate and apart from the occupancy level of the conventional NF beds using the same formula as cited in (a) above.

2. The NF shall submit the completed Provider Certification Statement for Long Term Care (see Appendix E, incorporated herein by reference), to report the actual calculation of the occupancy level determination of the NF. In addition to the occupancy level determination, the Certification Statement is also used to certify that the billing information is accurate, complete and in accordance with the rules of the New Jersey Health Services Program (Medicaid). The Certification Statement shall be submitted with the monthly Turn Around Document (TAD) (as set forth in Appendix Q, incorporated herein by reference) to the fiscal agent. Billing documents will be returned if the Certification Statement is not completed, signed and attached.

3. The calculation of the occupancy level shall include eligible bed reserve days in the determination of the Medicaid occupancy level.

10:63-1.6 Termination of a NF provider agreement

(a) The Division shall terminate a NF's provider agreement if the Division:

1. Receives notice from the New Jersey State Department of Health

or HCFA that the NF is no longer certified to provide NF services. In that case:

i. The provider agreement shall be terminated 23 days from the survey date if the New Jersey State Department of Health or the Secretary of the Department of Health and Human Services find that deficiencies pose immediate jeopardy to residents' health and safety.

ii. If the deficiencies do not pose immediate jeopardy to the resident's health and safety, the provider agreement shall be terminated ninety days from the survey date.

iii. The termination of provider agreement shall be rescinded if, prior to the effective date of termination, the Division is notified by the New Jersey Department of Health or the Secretary of the Department of Health and Human Services that the deficiencies have been satisfactorily corrected and the NF is certified to provide NF services; and

2. Determines that other good cause for such termination exists as cited at N.J.A.C. 10:49-11 or as a result of a pattern of aberrancies reported in a clinical audit as defined at N.J.A.C. 10:63-1.12.

10:63-1.7 Administrative appeal of denial, termination or non-renewal of NF certification or Medicaid Provider Agreement

(a) Any NF whose certification or Medicaid Provider Agreement is denied, terminated or not renewed shall have the opportunity to request a full evidentiary hearing before an administrative law judge, in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

1. In order to obtain a hearing, the NF shall submit, within 20 days from the date of the Division letter proposing termination, a written request to the Chief, Office of Legal and Regulatory Liaison, Division of Medical Assistance and Health Services, Mail Code # 3, CN 712, Trenton, New Jersey 08625-0712.

2. All hearings requested pursuant to this section shall be completed either before the effective date of the denial, termination or non-renewal, or within 120 days thereafter.

3. If the Division elects to provide a hearing after the effective date of denial, termination or non-renewal, the NF will be entitled to an informal reconsideration to be completed prior to the effective date of the denial, termination or non-renewal.

4. The informal reconsideration, if requested by the NF, will include the following:

i. Written notice by the Division to the NF outlining the findings upon which the denial, termination or non-renewal is based;

ii. Notice that the NF is allowed a reasonable opportunity to refute the findings in writing; and

iii. A written affirmation or reversal of the denial, termination or non-renewal.

(b) A (S)NF whose certification or Medicare/Medicaid provider agreement is denied, terminated or not renewed by HCFA, may request a hearing pursuant to 42 CFR 498.40 by submitting a written request to the Health Care Financing Administration, Division of Health Standards and Quality, Attn: Coordinator Hearing and Appeals, Federal Building Room 3821, 26 Federal Plaza, New York, New York 10278.

1. A final decision entered under the Medicare review procedures will be binding for purposes of Medicaid participation.

10:63-1.8 Admission, transfer and readmission; general

(a) Pursuant to P.L.1988, c. 97, a Medicaid participating NF shall not admit any individual who is Medicaid eligible or who may become Medicaid eligible within 180 days of admission to the facility, or an individual with mental illness (MI) or mental retardation (MR) subject to Pre-Admission Screening and Annual Resident Review (PASARR) requirements as defined at 42 CFR 483.102 regardless of payment source, unless that individual has been prescreened by the Medicaid District Office (MDO) registered professional nursing staff and determined appropriate for NF placement.

(b) A Medicaid eligible individual residing in a Medicaid participating NF who is transferred to an acute care hospital shall not require preadmission screening prior to returning to the same or another NF.

(c) A Medicaid eligible individual identified as MI residing in a Medicaid participating NF, who is admitted to a psychiatric unit for treatment, shall not be subject to PASARR requirements, prior to returning to the NF. However, if the resident's condition indicates a significant change in mental or behavioral status, the NF shall immediately secure an Annual Resident Review (ARR) as defined in N.J.A.C. 10:63-1.11(e).

(d) In cases of transfer of a NF resident with MI or MR to a hospital or another NF, the admitting NF is responsible for ensuring that copies of the resident's most recent PASARR resident assessment reports, SRA and current HSDP accompany the transferring resident.

(e) Payment will not be made by the New Jersey Medicaid program for NF

services provided to private paying patients who have applied for Medicaid benefits unless they have been authorized to receive NF services by the MDO. (See N.J.A.C. 10:63-1.11).

(f) The NF shall obtain a statement of the Medicaid recipient's budgetary information on the PA-3L Statement of Income Available for Medicaid Payment (see Appendix F, incorporated herein by reference) from the appropriate CWA.

(g) Notification of the approval or denial of NF services by the MDO shall be provided to the applicant and other individuals and agencies, as required in N.J.A.C. 10:49-10.4.

(h) In the event that a NF admits a Medicaid eligible recipient or an individual who may become Medicaid eligible within 180 days of admission without preadmission screening by the MDO, the effective date of the initial authorization will be the date of the MDO assessment. Facilities admitting such individuals without preadmission screening shall not be reimbursed by the New Jersey Medicaid program for any care rendered before the MDO assessment.

(i) When an inpatient is to be discharged from the hospital to a NF, the transfer shall, to the extent possible, be to a Medicare/Medicaid participating (S)NF when Medicare (Title XVIII) benefits are available.

(j) When an inpatient is discharged from the hospital to a Medicaid certified NF, the NF shall be responsible for securing a legible abstract or summary prepared by either the attending physician or the hospital and signed by attending physician, covering the Medicaid recipient's care in the hospital. This information shall be forwarded to the NF along with the HSDP and MDO authorization and where applicable, PASARR-related material.

(k) The NF shall submit a Notification From Long-Term Care Facility of the Admission or Termination of a Medical Patient, MCNH-33 Form, (see Appendix G, incorporated herein by reference) along with a copy of the hospital transfer form or its equivalent PA-4 Form, Certification of Need for Patient Care in Facility other than Public or Private General Hospital (see Appendix H, incorporated herein by reference) to the MDO serving the county where the NF is located, within two working days of admission.

(l) When a resident is transferred to a hospital, there is no change in the policy for readmission to the NF or the termination from the NF. The MCNH-33 form shall be completed, dated and signed for each readmission and termination of a Medicaid recipient. The MCNH-33 form shall reflect the room number and bed number to which or from which the Medicaid patient has been transferred or readmitted.

10:63-1.9 Waiting list

(a) The NF shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the NF are to be added to the top of the list as soon as the hospital notifies the NF of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-threatening situations or life-care community admissions.

1. The NF shall meet the following requirements:

   i. Maintain only one waiting list; this list shall reflect a roster updated on a regular basis, of all individuals who have applied for admission to the facility;

   ii. Reflect in chronological order the full name and address of the individual applying by the date the written application for admission is made;

   iii. Utilize the waiting list to admit individuals on a first-come, first-serve basis in the order in which they apply until the provider's Medicaid occupancy level equals the Statewide occupancy level, or the Medicaid occupancy level set forth in the provider's Certificate of Need, whichever is higher.

   iv. A file shall be maintained containing full documentation to support any valid reason why the individual whose name appears first on the waiting list is not admitted to the NF.

2. It shall be unlawful discrimination for any Medicaid participating NF whose Medicaid occupancy level is less than the Statewide occupancy level to deny admission to a Medicaid eligible individual who has been authorized for NF services by the MDO when a NF bed becomes available in accord with the waiting list.

   i. Under the provisions of N.J.S.A. 10:5-12.2, a facility with a residential unit or a Life-Care community may give its own residents priority when a NF bed becomes available.

10:63-1.10 Involuntary transfer initiated by the facility

(a) The Division recognizes that there may be problems in relocating infirm aged persons from a NF. The purpose of this rule is to specify the circumstances in which the involuntary transfer of a Medicaid recipient in a NF is authorized and to establish conditions and procedures designed to minimize the risks, trauma and discomfort which may accompany the involuntary transfer of a Medicaid recipient from a NF.

(b) This rule shall be interpreted consistent with the Federal requirement that care and service under the Medicaid program be provided in a manner consistent with the best interests of the resident.

(c) This rule shall apply to the involuntary transfer of a Medicaid recipient at the request of a NF. This rule shall not apply to the Division's utilization review process, nor to the movement of a Medicaid recipient to another bed within the same facility.

(d) A transfer of a Medicaid recipient which was not consented to or requested by the recipient or by the recipient's family or authorized representative shall be considered an involuntary transfer. A Medicaid recipient is a Medicaid eligible individual residing in a NF which has a Medicaid provider agreement. This includes Medicaid recipients over the minimum number stipulated in the agreement or an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility.

(e) A Medicaid recipient shall only be involuntarily transferred when adequate alternative placement, acceptable to the Division, is available. A Medicaid recipient may be transferred involuntarily only for the following reasons:

1. The transfer is required by medical necessity;
2. The transfer is necessary to protect the physical welfare or safety of the recipient or other residents;
3. The transfer is required because the resident has failed, after reasonable and appropriate notice, to reimburse the NF for a stay in the facility from his/her available income as reported on the PA-3L; or
4. The transfer is required by the New Jersey State Department of Health pursuant to licensure action or to the facility's suspension or termination as a Medicaid provider by the Division.

(f) In any determination as to whether a transfer is authorized by this rule, the burden of proof, by a preponderance of the evidence, shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled. Where a transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The effect of relocation trauma on the recipient;
2. The proximity of the proposed placement to the present facility and to the family and friends of the recipient; and
3. The availability of necessary medical and social services as required by Federal and State rules and regulations.

(g) The procedure for involuntary transfer shall be as follows:

1. The NF shall submit to the Division a written notice with documentation of its intention to and reason for the involuntary transfer of a Medicaid recipient from the facility;

2. If the MDO determines that an involuntary transfer is appropriate, the recipient and/or the recipient's authorized representative shall be given 30 days prior written notice by the Division that a transfer is proposed by the NF and that such transfer will take effect upon completion of the relocation program specified in (h). The written notice to the recipient and/or authorized representative will advise of the right to a hearing. If the recipient requests a hearing within 30 days of the date of the written notice, the transfer is stayed pending the decision following the hearing. In those instances where the Division determines that an acute situation or emergency exists, the transfer shall take effect;

3. The Division will comply with the hearing time requirements in State and Federal rules and regulations, unless an adjournment is requested by the appellant;

4. The hearing shall be conducted at a time and place convenient to the recipient. Notification shall be sent to all parties concerned;

5. All hearings shall be conducted in accordance with the Fair Hearing procedures adopted by the Division.

(h) The relocation procedure shall be as follows:

1. In the event the relocation of a recipient is the final Division determination, the Division shall afford relocation counselling for all prospective transferees in order to reduce as much as possible the impact of transfer trauma.

2. The staff of the transferring and receiving NFs shall assist in the transfer process, although responsibility and authority for the coordination and transfer rests with the Division and will include:

   i. Evaluation and review by appropriate MDO staff;

   ii. Initial recipient, family or authorized representative counseling;

   iii. Involvement of the recipient, family or authorized representative in the placement process with recognition of their choices;

iv. Recipient preparation and site visit for all able to do so within the capability of the transferring agent;

v. Accompaniment on the transfer day by a family member, authorized representative or attendant, unless the recipient otherwise requests;

vi. Follow-up counseling at the new location; and

vii. No right to an administrative hearing on a claim for failure to implement the requirements of this subsection for relocation counseling.

(i) No owner, administrator or employee of a NF shall attempt to have recipients seek relocation by harassment or threats. Such action by or on behalf of the NF may be cause for the curtailment of future admission of Medicaid recipients to the NF or for termination of the Medicaid Provider Agreement with the NF, depending upon the nature of the action.

(j) Any complaints regarding the handling of recipients relative to their transfer shall be referred to the Division for investigation and corrective action.

10:63-1.11 NF authorization process

(a) A Medicaid participating NF shall obtain authorization from the MDO prior to the admission of a Medicaid eligible or potentially Medicaid eligible individual. A Notification from Long Term Care Facility of Admission or Termination of a Medicaid Patient, form MCNH-33, shall be forwarded to the MDO serving the county where the NF is located, within two working days of admission or termination.

1. Pre-Admission Screening and Annual Resident Review (PASARR) shall be required for all individuals with mental illness (MI) or mental retardation (MR) who apply to, or reside in, Medicaid Certified NFs regardless of payment sources.

(b) The Medicaid RSN shall review the medical, nursing and social information obtained at the time of assessment, as well as any other supporting data to assess the individual's care needs and determine the appropriate setting for the delivery of needed services. The RSN will authorize or deny NF placement based on the service requirements of N.J.A.C. 10:63-2, and the feasibility of alternative placement and will designate the track of care.

1. For each NF applicant with MI or MR who is determined by the RSN to require NF placement, the State mental health or mental retardation authority (as appropriate) will determine whether the individual requires specialized services for MI or MR, prior to

issuance of the NF placement approval.

i. For the MI diagnosed individual, the RSN will request that the Psychiatric Evaluation form (see Appendix I, incorporated herein by reference), provided by the mental health authority, be completed by a Board eligible/certified psychiatrist and forwarded to the Division of Mental Health and Hospitals for determination of need for specialized services.

ii. For the MR diagnosed individual, the MDO will contact the appropriate Division of Developmental Disabilities staff to complete the determination for specialized services. In the case of an individual dually diagnosed with MI and MR, the determination by the mental health authority is completed first.

iii. The results of the MI or MR determinations will be forwarded to the MDO and will be conveyed to the referring individual. If no specialized services are required, the NF approval letter will accompany the MI/MR agency report.

iv. Individuals having Alzheimer's Disease or related organic dementia as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, Revised 1987 (DSM-III-R), shall be identified and the clinical records shall contain documentation which supports the diagnosis.

v. In the event the individual is determined by the State MI or MR authority to require specialized services, NF placement is inappropriate. The MI or MR authority will assist in finding appropriate placement/services for the individual.

vi. If the NF placement is denied based on failure to meet the NF requirements of N.J.A.C. 10:63-2, further screening by the State MI or MR authority is not required.

(c) As part of the PAS determination, the RSN will assign the track of care based on the following criteria:

1. Track I designates long-term NF care and shall be assigned in situations when long-term placement is required because clinical prognosis is poor, and when, during the assessment process, short-term stays are neither realistic nor predictable. Individuals designated for Track I services shall, at a minimum, require nursing services as required by N.J.A.C. 10:63-2.

i. A Track I designation shall not preclude the possibility of future discharge. The Medicaid Social Care Specialist will

monitor those individuals with discharge potential and consult with the RSN who will reassess the individual and update the Health Services Delivery Plan (HSDP) for a track change if appropriate.

2. Track II designates short-term NF care and shall be assigned in those situations when comprehensive and coordinated NF services are required to stabilize medical conditions, promote rehabilitation, or restore maximum functioning levels and to provide a therapeutic setting which assures family counseling and teaching in preparation for discharge to the community setting.

   i. Individuals designated for Track II services shall, at a minimum, require nursing services as defined by N.J.A.C. 10:63-2.

   ii. Individuals shall also be assigned to short-term NF stays, in spite of technically complex care needs and guarded prognosis, particularly when the individual is motivated towards NF alternatives and/or when caregivers, through case management intervention, may obtain services which make return to the community a viable option.

3. Track III designates long-term care services in the community and shall be assigned in the case of:

   i. Individuals who meet the requirements of N.J.A.C. 10:63-2, but can be appropriately cared for in the community with supportive health care services. These individuals may be eligible for Medicaid State Plan services or Home and Community-based Services Waiver Programs.

   ii. Individuals who may not require NF services as defined by N.J.A.C. 10:63-2, but would appropriately benefit from a structured therapeutic care setting such as can be provided in a Residential Health Care Facility, a group or boarding home, or other similar facility.

(d) The following procedures are to be utilized by the referent when seeking authorization through PAS prior to the admission of an individual to a Medicaid participating NF.

1. PAS procedure from a hospital setting: The hospital discharge planner/social work staff shall be responsible for identifying a potentially Medicaid eligible individual, a Medicaid eligible individual or an individual subject to PASARR requirements who may be at risk of NF placement on the basis of the "At-Risk Criteria for Nursing Facility Placement Referral to the Medicaid Office for PAS Evaluation" (see Appendix J, incorporated herein by reference).

These individuals shall be referred by the hospital to the MDO for assessment by the Medicaid RSN and, if appropriate, the county welfare agency (CWA) for eligibility determination.

i. NF approval: The RSN will conduct a PAS assessment utilizing the PAS-1 (see Appendix K, incorporated herein by reference) assessment instrument, and will verbally advise the hospital discharge planner/social worker and patient/family of the assessment decision and, if appropriate, will advise that an evaluation for PAS MI/MR specialized services is required. For a non-PAS MI/MR individual, the RSN will leave a copy of the Health Service Delivery Plan (HSDP) (see Appendix L, incorporated herein by reference), which identifies the individual's current and potential health problems and required care needs, and signed PAS-7 approval letter (see Appendix M, incorporated herein by reference), with the discharge planner/social worker. The original approval letter, signed by the RSN, will be sent by the MDO to the individual/family with copies to the CWA. For PAS MI/MR individuals, the signed approval letter will only be forwarded to the individual/family, with a copy to the referent, after the determination has been made that no specialized services are required.

(1) A copy of the HSDP, approval letter and, in appropriate cases, the MI/MR evaluation and determination or documentation which supports the diagnosis of Alzheimer's Disease or related organic dementia will be attached to the hospital discharge material and forwarded with the individual to the admitting NF.

(2) If the individual being transferred will be eligible for Medicare benefits, the transfer shall, to the extent possible, be made to a Medicare participating (S)NF.

ii. In the case of a NF denial, the RSN will verbally advise the hospital discharge planner/social worker and the individual and/or the individual's family of the assessment decision. The RSN will leave a signed copy of the PAS-8 denial letter (see Appendix N, incorporated herein by reference) with the discharge planner/social worker. The assessment decision may also result in a denial of any other long-term care services covered by the Medicaid program. The original denial letter, signed by the RSN, will be sent to the patient/family by the MDO, with copies to the CWA.

2. Individuals potentially eligible for Medicaid who are currently residing in a Medicaid participating NF who did not meet PASARR

criteria for MI/MR individuals prior to admission, and who may become eligible for Medicaid within six months, shall be referred by the NF to the MDO for a PAS evaluation via the MCNH-33 and PA-4 forms, utilizing the “At Risk Criteria for Nursing Facility Placement Referral To The Medicaid Office for PAS Evaluation.”

i. If the RSN approves NF placement of a potentially eligible individual, a copy of the HSDP and approval letter will be given to the NF designate for attachment to the clinical record.

(1) The CWA will forward the MCNH-33 Form (Notification from Long-Term Care Facility of Admission or Termination of Medicaid Patient) to the MDO indicating a change in the individual's status from private pay to Medicaid status.

ii. If a potentially eligible individual is denied NF, a denial letter will be issued to the NF designate by the MDO.

(1) If the MDO receives a subsequent referral for NF approval for a previously denied individual, the RSN shall review the presenting evidence to ensure that a significant change in the individual's condition has occurred.

3. Individuals residing in the community who are Medicaid-eligible recipients or who may become eligible for Medicaid within six months of admission, or an individual subject to PASARR requirements as defined at 42 CFR 483.102, seeking admission to a Medicaid participating NF shall be referred to the MDO for preadmission screening and, if appropriate, to the CWA for eligibility determination.

i. Upon receipt of a PA-4 Form (Certification of Need for Patient Care in Facility Other than Public or Private General Hospital) or physician statement which substantiates diagnosis and describes the individual's care needs, the Medicaid RSN will conduct a PAS assessment in accordance with (b) above. The individual will receive notification from the MDO, in writing, of approval or denial of NF. Copies of the letter will be sent by the MDO to the CWA. For individuals residing in the community who meet the PASARR/MI criteria, the attending physician may complete the Psychiatric Evaluation form, in the event that a board eligible/certified psychiatrist is not available.

ii. If NF placement is approved, the Medicaid social worker will assist the individual and/or family in selecting an appropriate NF.

(e) The procedure for NF continued stay shall be as follows:

1. The NF shall assess all individuals following admission, and periodically thereafter, utilizing the SRA in order to classify nursing service needs based on requirements contained in N.J.A.C. 10:63-2, and shall determine continued need for NF services, as follows:

   i. Individuals currently residing in NFs who meet the PASARR criteria for MI or MR as defined under 42 CFR 483.102 will be evaluated through the Annual Resident Review (ARR) process, which mandates that a review and determination of need for specialized services be completed by the State MI/MR authority (DMH & H/DDD) not less often than annually (42 CFR 483.114).

      (1) A PASARR Reassessment list, identifying those individuals subject to review by DMH & H and/or DDD, will be forwarded by the MDO to the NF. The NF shall update the NF PASARR Reassessment list to reflect deaths, transfers, discharges or changes in status affecting the criteria for PASARR requirements.

   ii. For individuals with mental illness, the NF shall ensure that the attending physician completes the Psychiatric Evaluation form, provided by the DMH & H, within the identified time frame and forwards that evaluation to DMH & H. The NF shall maintain a copy of the psychiatric evaluation on the individual's clinical record. The NF is not required to repeat the supporting diagnostic evaluation on individuals with Alzheimer's Disease or related organic dementias, providing that the initial documentation is maintained on the individual's current NF clinical record. The psychiatric evaluation performed by the attending physician will be reviewed by a DMH & H psychiatrist to determine specialized service needs. If the individual is found to require specialized service, the DMH & H will contact the NF regarding treatment options.

   iii. For individuals with mental retardation, staff from the Division of Developmental Disabilities (DDD) will visit NFs to perform MR evaluations. The MR evaluation process will include observation and/or interviews of each MR individual.

   iv. Individuals who are identified on the NF PASARR Reassessment list but are hospitalized or on therapeutic leave, shall have the annual review completed by the NF following readmission to the NF.

2. The Medicaid RSN shall periodically assess Medicaid recipients,

review the NF's assessments, patient classifications, and case mix reporting, and may recommend alternatives to NF stay or deny continued stay.

(f) Medical Social Care Specialists employed by the Division shall provide case management to Medicaid recipients, on an ongoing basis, following placement to monitor the provision of NF care in order to:

1. Assure that services are rendered as recommended by the HSDP and in accordance with the NF's evaluation of the individual's health service needs;
2. Assure the delivery of timely and coordinated services;
3. Provide direct or secure needed consultations with Medicaid professional or NF staff to promote service provision which is coordinated, effective and cost prudent; and
4. Facilitate discharge planning and promote appropriate placement to alternate care settings.

(g) Alternative care and discharge planning shall be conducted as follows:

1. Alternative care planning is the determination, initially and periodically, as to whether or not each Medicaid recipient requires initial placement or continued placement in an institutional setting and whether or not each recipient's nursing, social and other health care needs can be met through alternative institutional or non-institutional services.
    i. The RSN will authorize initial NF services after consideration and rejection of possible means of alternate care. Similarly, the possibility of alternate means of care will be a prime consideration in every reassessment of the care required by the individual.
    ii. The MDO staff will examine resident records for proof of continued vigilance and effort by the facility to utilize alternative means of care for all long-term residents.
        (1) Recipients designated as track II (short-term) shall be monitored closely by MDO professional staff to assure active participation by the facility in the discharge planning process.
    iii. If alternative care is available, accessible, and appropriate to the needs of the individual, the RSN shall deny the request for NF services.

iv. If an appropriate alternative plan of care becomes available and accessible for a person already approved for NF care who is awaiting placement, the RSN shall rescind the authorization for NF services.

v. Special Care NF (SCNF) residents who continue to require long-term supportive and restorative nursing services and therapeutic treatment for continued maintenance, in the absence of significant clinical change or special service needs, shall be approved for conventional NF placement (adult or pediatric) by the RSN after consideration and rejection of all possible means of alternate care.

(h) The NF shall notify the MDO, via the MCNH-33 Form, of all instances involving the termination of nursing facility services, which include but are not limited to, discharge, death, transfer and ineligibility.

(i) Authorization of out-of-State placement shall include the following additional conditions:

1. Authorization of out-of-State long-term care shall be prior authorized by the Division and shall be considered only when a required long-term care service is not available in New Jersey.

2. The out-of-State facility shall be licensed as a (S)NF by that state and the rate of reimbursement shall not exceed that authorized by the Title XIX program in the state in which the facility is located, or the reimbursement rate authorized by the New Jersey Health Services Program, whichever is lower.

3. Requests for prior authorization of out-of-State placement shall be accompanied by sufficient evidence of medical necessity to substantiate the request. The Division will review the records provided to determine the need for long-term care services and to determine the appropriateness of placing the recipient in a NF in New Jersey. The request shall be submitted to:

Department of Human Services
Division of Medical Assistance and Health Services
Office of Medical Care Administration
Mail Code # 8, CN 712
Trenton, New Jersey 08625-0712

4. Prior to submitting a request for out-of-State placement, the recipient shall comply with the requirements of the pre-admission screening as defined in this subchapter.

10:63-1.12 Clinical audit

(a) Clinical audit is a method of utilization control under the enforcement authority of Section 1902(a)(30)(A) of the Social Security Act, to monitor the continued utilization of and payment for NF care and services reimbursable under the Medicaid program. Clinical audit has as its major component verification of NF services provision.

(b) Professional staff from the Medicaid District Office (MDO) shall periodically conduct a post payment review of New Jersey Medicaid recipients for whom NF services have been provided. The review shall principally involve assessment of the Medicaid recipient's care needs and evaluation of treatment outcomes, based on direct observation of the recipient and examination of clinical and related records. The focus of the review shall be on the following areas:

1. Comparative analysis of NF claim reporting to recipient's identified care needs;
2. Appropriate utilization and provision of required services; and
3. Effectiveness and quality of provided services.

(c) Enforcement action will be taken by the Division as follows:

1. As a result of the clinical audits, aberrations in the reporting and/or provision of services and failure to comply with the requirements of this chapter shall be documented and reported to the NF for corrective action.
2. A pattern of practice of significant proportion wherein the NF has provided items or services at a frequency or amount determined unnecessary, or of a quality that does not meet the standards outlined in this chapter, will result in an increase, reduction or termination of services, and ultimate restriction of the NF participation in the Medicaid Program.

10.63-1.13 Clinical and related records

(a) An individual clinical record shall be maintained for each Medicaid recipient covering his or her medical, nursing, social and related care in accordance with accepted professional standards and licensing standards as set forth by the Department of Health Long Term Care Facilities Licensing Standards, N.J.A.C. 8:39. All entries on the clinical record shall be current, dated and signed by the appropriate staff member and readily available at the appropriate nurses' station for review by DMAHS staff.

(b) The clinical record of a deceased resident shall be properly completed. It shall include:

1. Written reports of visits made by the physician during the critical stage of illness;
2. Written documentation of death pronouncement completed by the qualified health professional as specified by the NF's policies and procedures;
3. Complete nurse's notes containing all necessary and pertinent information documenting the resident's condition during the illness and apparent demise, notification of physician and next of kin;
4. Autopsy records where appropriate; and
5. A written record of the disposition of the body of the deceased individual.

(c) All clinical records of discharged residents shall be completed promptly and shall be filed and retained for the duration required by N.J.S.A. 26:8-5.

(d) If the resident is transferred to or from another health care facility a copy of the resident clinical record or an abstract thereof, including the most recent HSDP, SRA and current copy of PASARR Specialized Service review for MI/MR individuals or the documentation which supports the diagnosis for individuals with Alzheimer's disease or related organic dementia, shall accompany the resident.

(e) All information contained in the clinical record shall be treated as confidential and shall be disclosed only to authorized persons.

(f) If the NF does not have a full or part-time medical records librarian, an employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed and preserved in accordance with accepted procedures. The designated individual shall be trained by, and must receive regular consultation from, a medical records librarian who is under written contract with the facility.

(g) Billing and financial records rules are as follows:

1. The Fiscal Agent Billing Supplement identifies the procedures required for the general use of the billing transaction forms and computer generated forms. All appropriate reports shall be retained until audited by the Division.
2. The facility shall establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of Medicaid recipient funds, which shall be subject to review and fiscal audit by

the State of New Jersey as may be required. A recipient shall be credited with the maximum amount of personal needs allowance funds authorized by Federal or State law for each month that such records or accounts are unavailable.

3. Any and all financial and other records relating to recipient's personal needs allowance accounts, income, cost studies, and billings to the Medicaid program shall be maintained and retained in accordance with professional standards and practices for the longest of the following periods of time:

   i. At least one year after the resolution of audit findings or the conclusion of recovery proceedings arising out of those audit findings (whichever is later) for the records that are audited;

   ii. One year after the conclusion of all hearings, appeals and/or other litigation with respect to audits of such records; or

   iii. Seven years.

4. The records described in (g)3 above shall be made available for audit upon the request of appropriate State and/or Federal personnel or their agents.

5. Claims for NF services that are older than 12 months will be rejected.

   i. A claim for payment for services shall be received by the fiscal agent no later than one year after the "from date of service" on the claim form (TAD). An adjustment request FD999 (see Appendix Q) for a paid claim shall be honored for a period of six months from the original date of payment;

   ii. For purposes of this time limitation, a claim is the submission of a TAD, provided by the fiscal agent for the New Jersey Medicaid program, indicating a request for reimbursement for authorized NF services provided to an eligible recipient and which has been returned to the fiscal agent within the time limit specified. An adjustment form (FD999) or an MCNH-33 shall not constitute a claim for payment;

   iii. Other timely filing information is located in the Administrative chapter at N.J.A.C. 10:49-7.2, "Timeliness of claim submission and inquiry".

10:63-1.14 Absence from facility due to hospital admission or therapeutic leave; bed reserve

(a) The bed reserve policy for hospital admissions is as follows:

1. The NF shall reserve and hold the same room and the same bed of the Medicaid recipient transferred to a general or psychiatric hospital for a period not to exceed 10 days. The NF shall determine the individual's status or whereabouts during or after the 10 day bed reserve period.

    i. If the resident is not readmitted to the same room or the same bed or the same NF during a bed reserve period, the NF requesting bed reserve reimbursement shall record on the resident's chart and make available for Division review, a justification for the action taken. Pending outcome of the Division's review, the facility may be subject to forfeiture of bed reserve reimbursement.

    ii. Said reserved bed shall remain empty and shall not be occupied by another individual during the bed reserve period.

2. Effective July 1, 1996, reimbursement, not to exceed 10 days, shall be at 90 percent of the rate the NF received prior to the transfer to the hospital.

    i. The recipient's available monthly income shall be applied against the per diem cost of care.

3. If readmission to the NF does not occur until after the 10 day bed reserve period, the next available bed shall be given to the Medicaid recipient. The recipient's name shall be placed on the chronological listing of persons waiting admission/readmission to the NF, and the recipient waiting for readmission shall have priority for the next available bed in the facility.

4. The bed reserve policy applies to any person in the NF eligible to receive Medicaid benefits; for example, a Medicare/Medicaid recipient who, at the time of transfer to the hospital, might be eligible for long-term care services under Medicare benefits.

5. Admission procedures (see N.J.A.C. 10:63-1.8) shall be followed when the Medicaid recipient has been readmitted following a period of hospitalization.

(b) Requirements concerning absence due to therapeutic leave are as follows:

1. The Medicaid program will reimburse NFs their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of

unused leave days may be carried over into the next calendar year. The facility shall maintain accurate leave day records on the Medicaid recipient's chart, for review by the Division.

2. A therapeutic leave shall include therapeutic or rehabilitative home and community visits with relatives and friends. Home visits shall be limited to therapeutic home visits only and shall not include hospital visits.

3. The absence of a Medicaid recipient from the facility for the purpose of therapeutic leave shall be authorized in writing by the recipient's attending physician and shall be included in the recipient's plan of care.

4. In those instances where a recipient is in more than one NF within a calendar year, the receiving facility shall determine the number of therapeutic leave days that have been allowed for payment by the sending facility within the same calendar year. A record of any leave days shall be a part of the information provided on the Patient Information Transfer Form.

5. The facility shall reserve and hold the same room and bed for the Medicaid recipient on a therapeutic home visit. Said bed shall not be occupied by another individual during the period of time in which the Medicaid recipient is on such leave.

6. Where a recipient's condition or situation requires more than 24 therapeutic leave days annually, as determined by the recipient's attending physician, prior authorization for the additional days shall be obtained from the MDO. The request for prior authorization shall be submitted in writing to the MDO Director, over the signature of the attending physician. A facility shall be reimbursed its per diem rate for reserving a bed for a Medicaid recipient for any additional days so authorized.

10:63-1.15 Complaints

(a) The Division will receive, document and investigate complaints from multiple sources and take appropriate corrective action as required. It is the Division's policy that the source of the complaint be held confidential, unless disclosure permission is obtained from the complainant.

(b) In addition to investigation by the Division, when complaints against a facility indicate the facility's failure to correct previously reported survey deficiencies or to comply with established licensure and Medicare/Medicaid certification standards, such complaint reports will be forwarded to the New Jersey State Department of Health and the Office of the Ombudsman for the Institutionalized Elderly for review and action. Any complaints or reports received

by the Division indicating legal violations will be referred to the office of the Attorney General for review and action, as required.

10:63-1.16 Utilization of resident's income for cost of care in the NF and for PNA

(a) After provision for the resident's Personal Needs Allowance (PNA) is met, and then after provision for other allocations such as maintenance of spouse and/or dependent's home are satisfied, the remainder of the Medicaid recipient's income shall be applied to the cost of care in the NF, which includes per diem, bed reserve and other allowable expenses.

1. The amount of income which shall be collected by the NF from the recipient, recipient's family or Representative Payee (if any) will be established in the process of determining eligibility and identified by form PA-3L, Statement of Income Available for Medicaid Payment, issued by the CWA. The NF shall collect all of the recipient's income to offset the Medicaid payment.
2. The NF shall notify the CWA immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the NF.
3. The New Jersey Medicaid program encourages families or any other concerned individual(s) to make voluntary contributions to the State of New Jersey on behalf of Medicaid recipients. Inquiries should be directed to the Division of Medical Assistance and Health Services, Bureau of Administrative Control, Mail Code #6, CN-712, Trenton, New Jersey 08625-0712.

(b) For all institutionalized aged, blind, and disabled individuals who are eligible for Medicaid, a designated amount of income as determined by State law (N.J.S.A. 30:4D-6a) shall be protected for personal needs allowance.

1. Certain individuals in a NF have no income, or insufficient income to provide a maximum amount of PNA. For those individuals not already deemed eligible for SSI, the facility shall insure that the application for SSI benefits has been made. PA-31’s for those recipients who only receive an SSI check can be obtained from the Bureau of Claims and Accounts, CN 712, Trenton, New Jersey 08625-0712.

(c) Each Medicaid recipient residing in a NF shall be permitted to accumulate a sum of money from the PNA which, when combined with other resources retained by or for the person, does not exceed the maximum resource standard in N.J.A.C. 10:71-4.5.

1. If the NF is handling the PNA, the facility shall closely monitor the PNA account and inform the recipient and/or his or her representative when the amount comes within $200.00 of the resource eligibility cap. If the PNA is in excess of the resource standard defined in N.J.A.C. 10:71-4.5, the recipient and/or his or her representative shall be advised of his or her right to reduce the excess monies and that the recipient may be terminated from Medicaid coverage, unless the amount in excess of the resource standard is expended.

2. The recipient may choose to reduce excess PNA by applying some of the accumulated PNA toward past expenditures paid for his or her care by the Medicaid program. Checks payable to the "Treasurer, State of New Jersey", may be directed to the Chief, Bureau of Administrative Control, Division of Medical Assistance and Health Services, Mail Code # 6, CN-712, Trenton, N.J. 08625-0712.

(d) Standards for management of PNA shall comply with Federal regulations at 42 CFR 483.10(c) and State licensing requirements at N.J.A.C. 8:39-4.1.

(e) The personal needs allowance (PNA) shall be used as follows:

1. The PNA is intended to meet the personal and incidental needs of a recipient residing in a NF, in keeping with his or her wishes. The PNA is not intended to be applied against outstanding balances for the cost of care.

2. The NF shall not charge for items the recipient has not requested, nor for any items about which the recipient has not been informed in advance that he or she will be billed.

3. NFs shall not charge for any item or service reimbursable under the Medicaid program. A facility may charge the difference between the cost of the brand a recipient requests and the cost of the brand generally provided by the facility, if the facility chooses to provide the requested brand. NFs shall not require the purchase of non-covered items as a condition for admission.

4. The basic items that NFs shall make available for recipient use under the Medicaid program include:

    i. Personal hygiene items such as soap, facial tissues, towels, washcloths, shaving materials (lotion, razor, razor blades), combs, hair brushes, shampoo, tooth brushes, tooth paste, laundry services, denture cleaner and adhesive, dental floss, deodorant, incontinent supplies, sanitary napkins,

disinfecting soaps or specialized cleaning agents, when medically indicated to treat special skin problems or to fight infections;

ii. Durable medical equipment such as wheelchairs, gerichairs, crutches, canes, walkers, commodes, Hoyer lifts, mattresses;

iii. Services, including electricity, TV antenna or cable hook-up when needed for acceptable reception, banking charges that are not deducted from the interest; and

iv. Basic room furnishings, such as chairs, table, fans, bed-spreads, curtains.

5. The facility may not mandate TV rental.

6. Examples of personal items for which PNA is intended are:

i. Small purchases, such as cosmetics, electric shavers, hair spray, special lotions or powders, clothes, brushes, tobacco or candy;

ii. Personal items, such as clothing, jewelry, watches, accessories, haircuts, beauty parlor services, newspapers or magazines;

iii. Personalization of living area with items requested by the resident, such as bed-spread, rug, pictures, furniture, radio or TV;

iv. Community contacts, such as home visits, transportation, trips to special events or places of interest, telephone calls, stationery, stamps or gifts;

v. Hobbies, such as games, photographic materials, aquariums, plants or audio or video tapes.

7. The PNA may be used to continue a bed reserve, if a recipient transferred to a hospital is unable to return within the 10-day bed reserve period. Payment shall be strictly voluntary, however, and shall be permitted only when the recipient's right to return to the NF (see N.J.A.C. 10:63-1.4) has been fully explained to the recipient and his representative. The recipient's request to use the PNA for this purpose shall be in writing. Under no circumstances shall the facility use overt or implicit coercion in this matter.

(f) A uniform accounting system shall be maintained by the facility as follows:

1. In compliance with Federal and State rules and regulations the NF shall accept fiduciary responsibilities for a Medicaid recipient's PNA

if the recipient and/or authorized representative requests that his or her PNA be managed by the facility. The NF shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each recipient's personal funds entrusted to the facility on the recipient's behalf. In compliance with Federal and State rules and regulations, the facility shall deposit any resident's personal funds in excess of $50.00 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts. The facility shall credit all interest earned on the resident's account to his or her account.

2. The PNA account and related supporting information, such as receipts, canceled check, bank statement, check register shall be maintained at the facility. The Division recommends that a direct deposit system be utilized.

3. A general ledger control account shall be established to record the total amount of PNA held in escrow by the facility.

4. A subsidiary ledger shall be established whereby each recipient's deposits and disbursements are recorded and the total of the recipient's balances reconciled to the general ledger control account each month, or as last reported by the banking facility.

5. When recording the recipient's income in a cash receipts journal, the PNA shall be segregated from the available income applied to the cost of the recipient's care. Within five days of receipt, the PNA shall be deposited directly into the interest bearing checking or savings account restricted for PNA. The general ledger control account shall reflect a credit posting to indicate the total PNA received during the month. Each recipient's subsidiary ledger account shall also be posted to record the deposits to the appropriate account.

6. To facilitate the recipient's access to the PNA, a portion of the total cash may be transferred periodically from the segregated checking/savings account to a petty cash fund. Such petty cash fund shall be maintained as an imprest fund. The amount of the imprest fund shall be reasonable and necessary for the size of the facility and needs of the recipients.

7. In compliance with Federal and State rules and regulations, the facility shall provide, at least quarterly, to the recipient and/or his or her authorized representative, an accounting of all transactions with regard to the PNA account. The amount of balance in the recipient's account shall be available for the recipient and/or his or her authorized representative on request.

8. Management of funds shall be as follows:

    i. For recipients who are able to manage their funds, a family member must have authorization in writing from the recipient for a specific amount before funds are disbursed from the PNA.

    ii. Recipients who are unable to manage their funds should have representative payees appointed.

    iii. Family members should withdraw funds only on presentation of receipts showing items purchased for the recipient, unless this appears to be a financial hardship for the family member.

    iv. In cases where there is an outside representative payee, and the recipient appears to be denied access to his PNA funds, or personal items are not being purchased for him, the facility shall take steps to ensure that the recipient's right to his PNA benefits is restored. Such steps may include warning letters to the representative payee, use of the NF attorney, and/or referrals to the Office of the Ombudsman for the Institutionalized Elderly and the Social Security Administration. In such cases, the facility may wish to request representative payeeship.

9. When drawing checks or cash to make disbursements from the recipient's PNA account, either an original invoice or a signed receipt from the recipient or an authorized representative shall be retained by the facility and referenced to the recipient's account. The receipt must stipulate the use of the funds or specify the items purchased.

10. When the facility draws checks on behalf of a recipient or reimburses the petty cash fund, disbursements of PNA shall be segregated from the operating expenses of the facility. At the end of each month, the general ledger control account shall be charged for the total PNA disbursed and each recipient's subsidiary ledger account shall reflect the monthly disbursements on that recipient's behalf.

11. Accumulated interest is the property of the recipient. Although a recipient's PNA may not be used for banking service charges, interest from the account may be used for this purpose.

12. Upon discharge or transfer to another NF or other place of residence, the facility shall provide the recipient with a final accounting statement and a check in the amount of the recipient's close-out balance within seven working days of the transfer; however, a recipient transferred to another NF shall be given the

option of authorizing the sending facility in writing to transfer any balance to the recipient's account at the receiving facility. The transfer of a PNA account from one facility to another shall be documented in writing, with a copy given to the recipient and/or his or her authorized representative. A recipient discharged or transferred shall have the right to the return of his or her personal property, such as, television, radio or other items.

13. Unclaimed PNA funds left behind by a discharged recipient who cannot be located or where the authorized representative cannot be located, shall be forwarded within 30 days to the Bureau of Administrative Control, Mail Code #6, CN 712, Trenton, New Jersey 08625-0712.

14. Within 10 days after the death of a Medicaid recipient, whether death occurred in the NF, in a hospital, or during a period of therapeutic leave, the NF shall send a written notice regarding the existence of PNA funds both to the CWA and the individual identified by the recipient as the person to contact. A NF shall exercise all reasonable efforts to locate and notify any family, representative payee or interested person acting on behalf of the deceased Medicaid recipient.

    i. The facility shall advise the contact person or responsible person that any claims made for PNA funds must be directed to the NF. When no CWA claim exists, the executor(rix) or administrator(rix), upon presentation of a letter of administration from the County Surrogate's Office, must be issued a check made payable to the estate of the deceased Medicaid recipient for the PNA funds. A check for the funds shall not be issued unless a Surrogate's letter is presented, except when a recipient dies intestate, leaving no surviving spouse, and the total value of the estate is less than $5,000; in such case, an affidavit of administration in accordance with N.J.S.A. 3B:10-4 is acceptable.

    ii. If there is an outstanding funeral bill which is deemed reasonable and there is no claim by the CWA or an executor/administrator, the NF may directly reimburse the funeral director from the PNA funds.

    iii. If no claim for PNA funds is made to the NF within 30 days of death, a check made payable to the "Treasurer, State of New Jersey" shall be forwarded to the Bureau of Administrative Control, Mail Code # 6, CN-712, Trenton, New Jersey 08625-0712. The following information shall be included:

        (1) An identification of the funds as unclaimed PNA funds

of the deceased Medicaid recipient;

(2) Recipient's name;

(3) HSP (Medicaid) Case Number;

(4) Date of death; and

(5) Amount enclosed for that recipient.

iv. If a claim is received by the NF after the PNA funds have been forwarded to the Bureau of Administrative Control and within five years of the Medicaid recipient's death, the claim must be referred to the Bureau for processing. After five years, all claims received by the NF must be referred to the State Treasurer.

v. Any transactions involving distribution of a deceased Medicaid recipient's PNA funds must appear on the NF's record for audit purposes.

(g) Questions regarding personal needs allowance administration, for example, procedures, policy, or use of funds, should be directed to the Director of the Medicaid District Office serving the NF.

10:63-1.17 Residents rights

(a) The NF shall ensure that each resident and his or her representative are informed of their rights upon admission and provided with a written statement of all resident rights, in accordance with 42 CFR 483.10 through 483.15, the Nursing Home Resident Rights Act, N.J.S.A. 30:13-1 et seq. and N.J.A.C. 8:39-4.1.

(b) The NF shall ensure that every resident who is entitled to Medicaid benefits shall receive a written statement of the services covered in the Medicaid per diem rate, those services required to be offered by the NF on an as-needed basis, and any charges not covered under the Medicaid program while in the facility.

(c) The NF shall notify each resident of his or her right under State law to make decisions concerning his medical care and his or her right to formulate an advance directive in compliance with the New Jersey Advance Directives for Health Care Act, P.L.1991, c. 201 and the advance directive provisions of the Omnibus Reconciliation Act of 1990, effective December 1, 1991 and Department of Health licensing requirements at N.J.A.C. 8:39-9.5.

10:63-1.18 Medicaid/Medicare

(a) The New Jersey Medicaid Program will reimburse for NF services

provided to combination Medicare/Medicaid recipients only after Medicare covered benefits have been fully utilized or when medically necessary services are not covered by the Medicare Program. (Exceptions-see (f)1i below).

1. A facility shall begin to bill Medicare for eligible residents immediately upon receipt of Medicare certification.

2. Failure by a facility to bill Medicare for Medicare/Medicaid eligible residents who meet the criteria for Medicare reimbursement for long-term care services, and who occupy Medicare certified beds may result in the termination of a facility's Medicaid provider agreement.

(b) Only skilled nursing facilities (SNFs), as defined in N.J.A.C. 10:63-1.2, certified by the Health Care Financing Administration (HCFA) and the New Jersey Department of Health are eligible to be reimbursed by Medicare for services rendered consistent with all Medicare requirements

(c) Medicare covers eligible beneficiaries needing post hospital skilled nursing care when they are placed in Medicare certified facilities.

(d) Medicare-eligible residents shall be placed in Medicare certified beds. If no Medicare certified beds are vacant at the time a Medicare-eligible person is admitted, a nursing facility patient who is occupying a Medicare certified bed but who is not eligible for Medicare reimbursement, may be relocated to allow the newly admitted patient to occupy a Medicare certified bed. In accordance with 42 C.F.R. 483.10(o), such relocation shall only occur when the individual agrees to the relocation. The nursing facility shall provide sufficient preparation and orientation to the resident to ensure a safe and orderly transfer. If consent is not granted, Medicaid shall reimburse the nursing facility for a timely submitted claim reimbursable under Medicaid rules.

(e) When Medicare benefits are denied, terminated or exhausted, because of coverage limitations, Medicaid may be billed on behalf of eligible recipients, provided that:

1. The services are allowable and provided within the standards and procedures established by the New Jersey Medicaid program as described in this manual. Medicaid shall reimburse a nursing facility if Medicare does not pay the claim and the claim is Medicaid reimbursable.

2. The certified facility provides written documentation of a denial of Medicare coverage:

    i. The certified facility shall indicate for all Medicare eligible beneficiaries through status reports, that the effort was made

to apply for Medicare reimbursement prior to Medicaid billing. Status reports affirming denial shall be obtained from the Medicare Fiscal Intermediary. Status reports shall consist of:

(1) A copy of form Inpatient Hospital and Skilled Nursing Facility Admission and Billing SSA-1453; or

(2) A notice of denial of coverage form Notice of Medicare Claim Determination SSA-1954 or form Notice of Medicare Claim Determination SSA-1955; or

(3) The facility statement of non-coverage, signed by an administrator or officer, which shall be accepted only under the limitation of benefits.

(f) Medicare Part A coinsurance may be paid by the New Jersey Medicaid Program, but the total combined Medicare/Medicaid reimbursement may never exceed the facility's Medicaid Nursing Facility rate. If the Medicaid recipient has available income during the coinsurance period of Medicare eligibility, it shall be used to offset the coinsurance charges, prior to billing Medicaid. New Jersey Medicaid will pay Part B Medicare insurance premiums for all eligible Medicare-Medicaid recipients. Claims for Part B services shall be billed to Medicaid only after Medicare benefits have been exhausted. Medicare timely filing requirements shall be met prior to the reimbursement of coinsurance by Medicaid.

1. Coinsurance and deductible payment shall be made as follows:

   i. Medicaid will not assume responsibility for payment of coinsurance for certain services under Part B Medical Insurance when the basis of payment is fee for service (for example, physicians or podiatrists). However, coinsurance is paid for certain other Part B Provider services where the basis for payment is not fee for service (for example, durable medical equipment), but only in those instances where the Medicare allowable reimbursement is less than the Medicaid established reimbursement for those items.

   ii. Medicaid will assume responsibility for deductible payments for Part B Medical Insurance services.

SUBCHAPTER 2 NURSING FACILITY SERVICES

10:63-2.1 Nursing facility services; eligibility

(a) Eligibility for nursing facility (NF) services will be determined by the RSN, based on a comprehensive needs assessment which demonstrates that the recipient requires, at a minimum, the basic NF services described in N.J.A.C. 10:63-2.2.

1. Individuals requiring NF services may have unstable medical, emotional/behavioral and psychosocial conditions which require ongoing nursing assessment, intervention and/or referrals to other disciplines for evaluation and appropriate treatment. Typically, adult NF residents have severely impaired cognitive and related problems with memory deficits and problem solving. These deficits severely compromise personal safety and therefore, require a structured therapeutic environment. NF residents are dependent in several activities of daily living. Dependency in activities of daily living (ADL) may have a high degree of individual variability. Each separate ADL may be classified as either independent, requiring some assistance, or totally dependent.

    i. Children requiring NF services exhibit functional limitations identified either in terms of developmental delay requiring nursing care over and above routine parenting or are limited in terms of specific age-appropriate physical and cognitive activities, functional abilities (ADL) or abnormal behavior, as demonstrated by performance at home, school or recreational activities.

        (1) Children who have achieved developmental milestones within appropriate time frames and who require only well child care and/or treatment of acute, time limited illnesses or injuries shall not be eligible for NF services.

2. NF residents shall be those individuals who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the individual. Care and treatment shall be directed toward development, restoration, maintenance, or the prevention of deterioration. Care shall be delivered in a therapeutic health care environment with the goal of improving or maintaining overall function and health status. The therapeutic environment shall ensure that the individual does not decline (within the confines of the individual's right to refuse treatment) unless the individual's clinical condition demonstrates

that deterioration was unavoidable.

(b) All Medicaid participating NFs shall provide or arrange for services in accordance with statutory and regulatory requirements under 42 CFR 483 and Department of Health licensing rules at N.J.A.C. 8:39. Reimbursement of NF services is discussed in N.J.A.C. 10:63-3.

(c) NF services shall be delivered within an interdisciplinary team approach. The interdisciplinary team shall consist of a physician and a registered professional nurse and may also include other health professionals as determined by the individual's health care needs. The interdisciplinary team performs comprehensive assessments and develops the interdisciplinary care plan.

10:63-2.2 Delivery of nursing services

(a) The NF shall provide 24-hour nursing services in accordance with the minimum standards set forth by the New Jersey Department of Health Long Term Care Facilities Licensing Standards, N.J.A.C. 8:39, which is incorporated herein by reference. Employing the service-specific case mix system to classify recipients with similar care requirements and resource utilization, the NF shall provide nursing services by registered professional nurses, licensed practical nurses and nurses aides on the basis of the total number of residents multiplied by 2.5 hours/day; plus the total number of residents receiving each of the following services:

1.	Tracheostomy	1.25 hours/day
2.	Use of respirator	1.25 hours/day
3.	Head trauma stimulation/advanced neuromuscular/orthopedic care	1.50 hours/day
4.	Intravenous therapy	1.50 hours/day
5.	Wound care	0.75 hour/day
6.	Oxygen therapy	0.75 hour/day
7.	Nasogastric tube feedings and/or gastrostomy	1.00 hour/day

(b) Nursing service requirements in (a) above shall be classified and recorded for each individual Medicaid recipient on Section Q (see Appendix 0, incorporated herein by reference) of the New Jersey Standardized Resident

Assessment (SRA) instrument. Section Q shall be reviewed and revised to reflect changes in the recipient's nursing service requirements at the time of each mandated review and revision of the SRA during the comprehensive assessment process and development of the interdisciplinary care plan. Section Q is signed and dated by the registered professional nurse who completes the assessment. In the absence of necessary change to Section Q at the time of review, the current form may be signed and redated indicating that no change in nursing service requirements was identified.

(c) The NF provision of 2.5 hours/day means services provided to Medicaid recipients who are chronically or subacutely ill and require care for these entities, disease sequela or related deficits.

(d) The 2.5 hours of nursing care shall incorporate the principles of nursing process which consists of ongoing assessment of the recipient's health status for the purpose of planning, implementing and evaluating the individual's response to treatment.

1. In his or her capacity as coordinator of the interdisciplinary team, the registered professional nurse, who has primary responsibility for the recipient, shall perform, beginning on the day of admission, a comprehensive assessment of the recipient to provide, communicate and record within the SRA: baseline data of physiological and psychological status; definition of functional strengths and limitations; and determination of current and potential health care needs and service requirements.

    i. In addition to clinical observations and hands-on examination of the Medicaid recipient, the licensed nurse shall review the HSDP and any available transfer records. The assessment data shall be coordinated by the registered professional nurse with oral or written communication and assessments derived from other members of the interdisciplinary team and shall be consistent with the medical plan of treatment. The initial comprehensive assessment (SRA) shall be completed no later than 14 days after admission and on an annual basis thereafter. If there is a significant change in the recipient's status, the NF shall complete a full comprehensive assessment involving the SRA. The registered professional nurse shall analyze the data and utilize the resident assessment protocols (RAPs) to focus problem identification, structure the review of assessment information and develop an interdisciplinary care plan which documents specific interventions unique to the individual, which define service requirements and facilitate the plan of treatment.

2. The interdisciplinary care plan shall identify and document the recipient's problems and causative or contributing factors and is derived from the comprehensive assessment. The plan shall be coordinated and certified by the registered professional nurse with active participation of the Medicaid recipient and/or significant other. The scope of the plan shall be determined by the actual and anticipated needs of the Medicaid recipient and shall include: physiological, psychological and environmental factors; recipient/family education; and discharge planning. The care plan shall be a documented, accessible record of individualized care which reflects current standards of professional practice and includes:

    i. Identified problems (needs) and contributing factors;

    ii. Specific and measurable objectives (outcomes) which provide a standard for measurement of care plan effectiveness;

    iii. The plan of care shall emphasize interventions which prevent deterioration, maintain wellness and promote maximum rehabilitation; and

    iv. The initial interdisciplinary care plan shall be completed and implemented within 21 days of admission and shall be reviewed regularly and revised as often as necessary, according to all significant changes in a recipient's condition and to attainment of and/or revisions in objectives as indicated. Review and appropriate revision shall be done at least every three months and whenever the clinical status of the recipient changes significantly or requires a change in service provision.

3. Implementation of the interdisciplinary care plan and delivery of nursing care shall be documented within nursing progress (clinical) notes, which shall establish a format for recording significant observations or interaction, unusual events or responses, or a change in the Medicaid recipient's condition, which requires a change in the scope of service delivery. Specific reference shall be made to the recipient's reactions to medication and treatments, rehabilitative therapies, additional nursing services in accordance with N.J.A.C. 10:63-2.2(a), observation of clinical signs and symptoms, and current physical, psychosocial and environmental problems. Nursing entries shall be made as often as necessary, based on the Medicaid recipient's condition and in accordance with the standards of professional nursing practice.

4. Assessment review is the process of ongoing evaluation of health service needs and delivery. Nursing actions shall be analyzed for

effectiveness of care plan implementation and achievement of objectives. The registered professional nurse, along with the Medicaid recipient and/or significant other, shall participate with the team in the ongoing process of evaluation, reordering priorities, setting new objectives, revision of plans for care and the redirection of service delivery.

i. The assessment review process shall be conducted quarterly. Conclusions shall be documented on the SRA quarterly review, and the interdisciplinary care plan shall be updated to provide a comparison of the Medicaid recipient's previous and present health status, and to outline changes in service delivery and nursing interventions. The assessment review shall identify the effectiveness of, and the Medicaid recipient's response to, therapeutic interventions, and, whenever possible, the reason for any ineffectiveness in recipient responses.

(e) Restorative nursing is a primary component in the delivery of the 2.5 hours of nursing care. Restorative nursing addresses preventable deterioration and is directed toward assisting each recipient to attain the highest level of physical, mental, emotional, social and environmental functioning. Restorative nursing functions shall include:

1. Supervision, direction, assistance, training or retraining in all phases of activities of daily living to promote independence or growth, and to develop or restore function to the extent the individual is able (bathing, dressing, toileting, transfers and ambulation, continence, and feeding);

2. Discharge planning which focuses on assessment of the caregiving potential of the resident, family or significant other. The nurse shall, along with other members of the interdisciplinary team, extend the assessment beyond the needs of the resident to include assessment of the caregivers' ability to provide long-term care and their need for information on normal growth, development or aging; care needs; medication and treatment; home safety and the need for additional supports, both formal and informal, in preparation for the resident's return to the community;

3. Proper positioning of the individual in bed, wheelchair or other accommodation to prevent deformities and pressure sores;

4. Program of bowel and bladder retraining for incontinence, in accordance with the individual's potential for restoration;

5. Range of motion exercises, active and passive, as necessary;

6. Follow-up care as required for physical therapy, occupational

therapy and/or speech-language pathology services;

7. Follow-up care as required for uncomplicated plaster care; assistance with adjustment to and use of prosthetic and/or orthotic devices;

8. Routine care and maintenance of ostomies (that is, cleansing and appliance change and instruction for self care);

9. Resident education relative to health care, special diet, and, if ordered by the physician, self-administration of medication;

10. Encouragement of resident participation in, and monitoring resident response to, individual or group activities and therapies for psychosocial maintenance and restoration; and

11. In a NF providing care to children, the application of the principles of growth and development in planning, implementing and evaluating care needs; consideration of the child's physical and developmental functioning with respect to his/her need for recreational and educational stimulation and growth; and application of behavior modification techniques in the management of developmental and disability-related behavior problems.

(f) The 2.5 hours of nursing care provided shall also include, but not be limited to, the following nursing procedures, therapies and activities:

1. Safe and appropriate administration of medications;

2. Emergency care (for example, oxygen, injections, resuscitation);

3. Observation, recording, interpretation and reporting of vital signs, height and weight;

4. Intake and output recording, as clinically indicated;

5. Catheter care including intermittent or continuous bladder irrigations, intermittent catheterizations, and use of other drainage catheters;

6. Preparations for laboratory procedures and collection of laboratory specimens;

7. Telephone pacemaker or electrocardiogram checks;

8. Terminal illness management, when there is need for supportive services and intensive personal care;

9. Heat or cold treatments as ordered by the physician;

10. Risk determination for pressure sores using a standardized assessment instrument and implementation of necessary

preventive measures as clinically indicated (for example, mattress overlays or cushions, positioning schedule, range of motion, nutrition support, skin care and skin checks);

11. Care of Stage I and II pressure sores, as follows:

    i. A Stage I pressure sore is an area of redness which does not respond to local circulatory stimulation. It involves the epidermis. No break in the skin is evident;

    ii. A Stage II pressure sore is a partial thickness, loss of skin layers with epidermis and possibly dermis involvement. A shallow ulcer or blister appears, and the site is free of necrotic tissue;

    iii. An individual who enters the NF without pressure sores should not develop them unless the individual's condition demonstrates pressure sores were unavoidable. Treatment of superficial skin tears, wounds, excoriation and lesions shall be included in the 2.5 hours of care;

12. The long-term care of a simple stabilized tracheostomy with minimal care and supervision by licensed staff;

13. Uncomplicated administration of respiratory therapies requiring minimal staff assistance, direction, and supervision;

14. Protection of individuals through the appropriate use of universal precautions, in accordance with Centers for Disease Control guidelines published in the Morbidity and Mortality Weekly Report, volume 38, number 5-6 (Centers for Disease Control, Atlanta, GA 30333);

15. Appropriate use of restraints (physical and/or chemical), in accordance with the physician's order and N.J.A.C. 8:39 licensure standards, and clinically appropriate measures to guarantee the safety of individuals (for example, side rails);

16. Observation, supervision and recording of basic nutritional states for maintenance of current health status and prevention of deficiencies;

17. Observation, supervision and instruction concerning special dietary requirements during ongoing adjustment to treatment regimen for diagnosed medical conditions;

18. Nursing treatment, observation and/or direction of mental status impairment which necessitates nursing supervision and intervention (for example, marked confusion and/or disorientation in one, two, or three spheres (time, place and/or person), marked memory loss, severe impairments in judgment); and

19. Emotional support and counseling on an ongoing basis, and during adjustment to impaired physical and mental states, including observation for changes in affect and mood which may require special precautions and/or therapies.

(g) Nursing services requiring additional nursing hours above 2.5 hours/day are set forth in (g)1 through 7 below. An individual recipient may require one or more additional nursing services, however, each category of additional nursing service may only be counted once for each individual recipient.

1. Wound care (.75 hours), which includes, but is not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites. In this category are Stage II pressure sores encompassing two or more distinct lesions on separate anatomical sites, Stage III and Stage IV pressure sores.

    i. Tube site and surrounding skin related to ostomy feeding is not to be counted as an additional nursing service unless there are complicating factors such as: exudative, suppurative or ulcerative inflammation which require specific physician prescribed intervention provided by the licensed nurse beyond routine cleansing and dressing.

    ii. Stage III and Stage IV are defined as follows:

        (1) Stage III. The wound extends through the epidermis and dermis into the subcutaneous fat and is a full thickness wound. There may be inflammation, necrotic tissue, infection and drainage and undermining sinus tract formation. The drainage can be serosanguinous or purulent. The area is painful.

        (2) Stage IV. The pressure wound extends through the epidermis, dermis, and subcutaneous fat into fascia, muscle and/or bone. Eschar, undermining, odor and profuse drainage may exist.

        (3) Other wounds which may be categorized under wound care as defined in (f)1 above include:

            (A) Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the individual is receiving antibiotic therapy;

            (B) Wounds with a drain or T-Tube;

            (C) Wounds which require irrigation or instillation of a sterile cleansing or medicated solution and/or

packing with sterile gauze;

(D) Recently debrided ulcers;

(E) Wounds with exposed internal vessels or a mass which may have a proclivity for hemorrhage when dressing is changed (for example, post radical neck surgery, cancer of the vulva);

(F) Open wounds, widespread skin disease or complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies; and

(G) Complicated post-operative wounds which exhibit signs of infection, allergic reactions or an underlying medical condition that affects healing.

2. Tube feedings (1.00 hr/day), which include nasogastric tube, and percutaneous feedings may be used if the feedings are required to treat the individual's condition after all non-invasive avenues to improve the nutritional status have been exhausted with no improvement. The clinical record shall document the non-invasive measures provided and the individual's poor response. The record shall also indicate the medical condition for which the feedings are ordered. Included in this service is the routine care of the tube site and surrounding skin of the surgical gastrostomy.

   i. Feeding tubes that are routinely clamped off and are no longer the primary source of dietary administration and nutritional support are covered under the basic 2.5 hours/day of nursing service and shall not be counted as an additional nursing service.

3. Oxygen therapy (.75 hrs/day), which includes complex provision of oxygen/respiratory therapies due to the nature of the individual's condition, type or multiplicity of procedures required and the need for therapies for which individual is dependent upon administration by licensed staff such as positive pressure breathing therapy, nasal BiPAP and aerosol therapy.

4. Tracheostomy (1.25 hrs/day), which includes new tracheostomy sites and complicated cases involving symptomatic infections and unstable respiratory functioning.

5. Intravenous Therapy (1.50 hrs/day), which includes clinically indicated therapies ordered by the physician, such as central venous lines, Hickman/Broviac catheters, heparin locks, total

parenteral nutrition, clysis, hyperalimentation and peritoneal dialysis. When clinically indicated, intravenous medications should be appropriately and safely administered within prevailing medical protocols. If intravenous therapy is for the purpose of hydration, the clinical record shall document any preventive measures and attempts to improve hydration orally, and the individual's inadequate response.

6. Respirator use (1.25 hrs/day), which includes care for individuals who are stable and no longer require acute or specialized respirator programs and who require mechanical ventilation to oxygenate their blood. Ongoing assessment and intervention by a licensed nurse is needed. The individual's treatment plan should include protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician.

7. Head trauma stimulation/advanced neuromuscular/orthopedic care (1.50 hrs/day), as follows:

    i. Care of head trauma is directed toward individuals who are stable (have plateaued) and can no longer benefit from a rehabilitative unit or unit for specialized care of the injured head. Individuals shall have access to and periodic reviews by such specialists as a neurologist, neuropsychologist, psychiatrist and vocational rehabilitation specialist, in accordance with their clinical needs. There shall also be contact with appropriate therapies, such as physical therapy, speech-language pathology services and occupational therapy. The distinguishing characteristic for add-on hours for head trauma is the necessity for ongoing assessment and follow-up by licensed nursing personnel focusing on early identification of complications, and implementation of appropriate nursing interventions. Nursing protocols may be initiated which are specifically designed to meet individual needs of head injured individuals. The nurse may also supervise a coma stimulation program, when this need is identified by the interdisciplinary team.

    ii. Advanced neuromuscular care needs will be identified by the physician for individuals during an unstable episode or where there is advanced and progressive deterioration in which the individual requires observation for neurological complications, monitoring and administration of medications or nursing interventions to stabilize the condition and prevent unnecessary regression.

    iii. Advanced orthopedic care is the care of plastered body parts with a pre-existing peripheral vascular or circulatory condition requiring observations for complications and

monitoring and administration of medication to control pain and/or infection. Such care also involves additional measures to maintain mobility; care of post-operative fracture and joint arthroplasty, during the immediate subacute post-operative period involving proper alignment; teaching and counseling and followup to therapeutic exercise and activity regimens. Individuals in this group shall be identified by the physician as needing advanced orthopedic care. If the requirement for advanced orthopedic care exceeds 30 days, clinical need must be demonstrated and clearly documented by the interdisciplinary team.

10:63-2.3 Physician services

(a) General requirements for physician services shall be as follows:

1. Each Medicaid recipient's care shall be under the supervision of a New Jersey licensed attending physician chosen by, or agreed to by, the Medicaid recipient, or if the recipient is incompetent, by the family or legal guardian.

2. In a NF providing care to children, the attending physician shall be board certified/eligible by the American Board of Pediatrics or the American Board of Family Practice.

3. The NF shall maintain arrangements which assure that the services of a New Jersey licensed physician who can act in case of emergency, are continuously available.

(b) Requirements for a medical director shall be as follows:

1. The NF shall retain, pursuant to a written agreement, a physician licensed under New Jersey State Law to serve as Medical Director on a part-time or full-time basis as is appropriate for the needs of the residents and the size of the facility. The Medical Director shall be responsible for the overall development of medical policies and coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to the residents and to monitor the health status of the employees.

   i. In a NF providing care exclusively to children, the medical director shall be certified/eligible by the American Board of Pediatrics or the American Board of Family Practice.

2. The duties of the medical director shall include, but not be limited to, the following:

   i. Participation in the development of written policies, rules and

regulations which are approved by the governing body of the facility;

ii. Delineation of the responsibilities of the attending physician(s) and ensuring that visits by medical consultants occur as needed;

iii. Acting as liaison between administration and medical staff for improving services and ensuring the carrying out of responsibilities of the medical staff;

iv. Surveying the execution of resident care policies, which includes a periodic evaluation of the adequacy and appropriateness of the services of health professional and supporting staff and monitoring the health status of the facility's employees;

v. Participation in the review of incidents and accidents that occur on the premises to identify hazards to health and safety of employees and residents. The Medical Director is given appropriate information to help ensure a safe and sanitary environment for residents and personnel;

vi. Ensuring that the medical regimen is incorporated in the resident care plan;

vii. Participation in the facility's quality assurance program through meetings, interviews and/or preparation or review of reports regarding infection control, pharmaceutical services, credentials, resident care, etc.;

viii. Collaboration with administration in the planning of educational programs for facility staff;

ix. Reviewing written reports of surveys and inspection and making recommendations to the administrator;

x. Participation in special projects, such as medical evaluation studies;

xi. Negotiating and resolving problems with the medical community;

xii. Responding quickly and appropriately to medical emergencies which are not handled by another attending physician; and

xiii. Ensuring that, for each Medicaid recipient, there is a designated primary and alternate physician who can be contacted when necessary.

(c) Requirements for an attending physician shall be as follows:

1. Initial medical findings and physician's orders;

i. There shall be available to the NF, prior to, or at the time of admission, resident information which includes medical history, diagnosis, current medical findings, medical plan of care and rehabilitation potential.

ii. If the resident is transferred from another health care facility, a transfer summary of the course of treatment including findings of diagnostic services shall accompany the resident. If the transfer summary information is not available in writing in the facility upon admission of the resident, it shall be obtained by the facility after admission.

iii. There shall be orders from a physician for the immediate care of the resident, to include, at a minimum, medications, dietary needs, hygiene, level of activity, and special therapies, if applicable. A current health facility discharge summary containing the information is acceptable.

(1) If medical orders for the immediate care of the resident are unobtainable at the time of admission, the physician with responsibility for emergency care shall give temporary orders.

(2) Each resident shall be examined by a physician within five days before, or 48 hours after admission.

2. The attending physician shall also be responsible for initial and ongoing medical evaluation, as follows:

i. The medical assessment of the Medicaid recipient shall begin at the time of admission to a NF and shall be the foundation for the planning, implementation, and evaluation of medical services directed toward the care needs of the resident.

ii. The medical assessment shall consist of the complete, documented, and identifiable appraisal (from the time of admission to discharge) of the Medicaid recipient's current physical and psychosocial health status. The medical assessment shall be utilized to determine the existing and potential requirements of care. The evaluation of the data obtained from the medical assessment shall lead to the development of the medical services portion of the interdisciplinary care plan. The assessment data shall be available to all staff involved in the care of the resident.

iii. The tools utilized in the assessment process shall include a

complete history and physical examination, eliciting medically defined conditions and prior medical history, admission form(s), transfer form(s), Health Service Delivery Plan (HSDP), and data from other members of the interdisciplinary team.

iv. Other Medicaid recipient data utilized should include:

(1) Clinical physical and psychological symptoms and signs;

(2) Capabilities to perform functional activities of daily living;

(3) Sensory (hearing, speech, and vision) and physical impairments;

(4) Medical necessity of additional nursing services, in accordance with N.J.A.C. 10:63-2.2;

(5) Nutritional status and requirements;

(6) Special treatments or procedures (including laboratory and other diagnostic services);

(7) Psychosocial status;

(8) Dental condition;

(9) Activities potential;

(10) Rehabilitation potential;

(11) Cognitive status;

(12) Drug therapy;

(13) Safety requirements;

(14) Attention to comfort and dignity; and

(15) Plans of alternative care, when applicable.

v. In addition to the requirements in (c)2iv above, medical evaluations of children in a NF shall include the following:

(1) Assessment of developmental status;

(2) Measurement and recording of head circumference until the age of 24 months;

(3) Measurement and recording of blood pressure, from age three;

(4) Assessment of immunization status and

administration of appropriate immunizations according to the recommendations of the Academy of Pediatrics;

(5) Hemoglobin determination once during each of the following times: six to eight months, two to six years, and 10 to 12 years of age;

(6) Urinalysis-a minimum of once between age 18 and 24 months and once between 13 and 15 years of age;

(7) Tuberculin testing once during each of the following times: nine to 12 months, four to six years, and 10 to 15 years of age; and

(8) Lead screening (EP Test) upon admission.

vi. As an active member of the interdisciplinary team, the attending physician shall:

(1) Identify and document the medical needs of the Medicaid recipient;

(2) Be attentive to and develop individualized preventive, maintenance, restorative and/or rehabilitative medical interventions in relation to the physical and psychosocial needs identified in order to prevent deterioration, maintain wellness and promote maximum development or restoration;

(3) Be observant of clinical signs and symptoms of the Medicaid recipient;

(4) Perform, annually, a complete physical examination, as the medical component of the comprehensive resident assessment;

(5) Periodically evaluate and be cognizant of the Medicaid recipient's total clinical record including the interdisciplinary care plan and facilitate necessary changes as medically indicated;

(6) Identify and document the effectiveness of, and the Medicaid recipient's response to, therapeutic intervention such as medications, treatment and special therapies, and, where possible, the reason for any ineffectiveness in the Medicaid recipient's responses.

3. Physician progress notes shall:

i. Be maintained in accordance with accepted professional standards and practices as necessitated by the Medicaid

recipient's medical condition;

ii. Be a legible, individualized summary of the Medicaid recipient's medical status and reflect current medical condition, including clinical signs and symptoms; significant change in physical or mental conditions; response to medications, treatments, and special therapies; indications of injury including the date, time and action taken; medical necessity for extent of change in the medical treatment plan; and

iii. Be written, signed, and dated at each visit.

4. Physician orders shall be completed as follows:

i. Orders concerning medications and treatment shall be in effect for the specified number of days indicated by the physician, but in no case shall exceed a period of 60 days. Vague and blanket orders shall not be acceptable. The physician shall review all orders and re-confirm in writing with signature and date, when any orders are continued.

ii. Stop orders shall conform with the standards of the Formulary Committee of the facility.

5. Physician visits shall be conducted as follows:

i. All required physician visits shall be made by the physician personally, or a physician assistant or nurse practitioner, as permitted by State law.

(1) For the first 90 days, the Medicaid recipient shall be visited and examined every 30 days. Thereafter, with written justification, the interval between visits may be extended for up to 60 days.

(2) Additional visits shall be made when significant clinical changes in the Medicaid recipient's condition require medical intervention.

10:63-2.4 Rehabilitative services

(a) Rehabilitative services include physical therapy, occupational therapy, and speech-language pathology services provided by a qualified therapist for the purpose of attaining maximum reduction of physical or mental disability and restoration of the resident to his best functional level. Rehabilitative services shall be made available to Medicaid recipients as an integral part of an interdisciplinary program. Rehabilitative services shall not include physical medicine procedures administered directly by a physician, or physical therapy which is purely palliative, such as the application of heat per se, in any form; massage; routine calisthenics or group exercises; assistance in any activity; use

of a simple mechanical device; or other services not requiring the special skill of a qualified therapist.

1. If the attending physician orders an evaluation for physical, speech-language pathology services or occupational therapy, an appropriately qualified therapist shall perform an assessment to determine the need for services. The therapist shall complete a written report of therapy recommendations within 14 days of the physician's order and shall include the report in the clinical record, for review by the attending physician.

2. Rehabilitative treatment shall be provided under the direct supervision and in the presence of a qualified therapist or physiatrist, only upon the written signed order of the physician who shall indicate modality and frequency and duration of treatments. The attending physician shall evaluate each resident's response to therapeutic services on a monthly basis. Continuance of said services shall be based on documentation of a potential for significant functional improvement within a reasonable time frame.

    i. Rehabilitation therapy services shall be integrated with medical, nursing, recreational and social services to promote development or restoration of the resident to his/her maximum potential and reviewed in conjunction with other periodic reviews of the interdisciplinary care plan.

3. Rehabilitative services shall be provided by qualified therapists employed by or under contract to:

    i. An approved home health agency;

    ii. A licensed or accredited general or special hospital;

    iii. An approved independent outpatient health facility; or

    iv. A NF.

4. Rehabilitative services are considered part of the NF's cost. Reimbursement for such services is included in the NF's per diem rate.

10:63-2.5 Resident activities

(a) An ongoing resident activities program shall be established as an adjunct to the treatment program and an integral component of the interdisciplinary plan of care. The program shall be a planned schedule of appropriate social, physical, spiritual, psychological, leisure, cognitive, vocational and educational activities designed to meet the needs, interests, and behaviors of all residents, whether ambulatory, chair bound, or bedfast. In a facility providing care to children, activities programming shall be geared to the child's developmental and

behavioral needs.

(b) Activities shall enable the residents to maintain a sense of usefulness and self-respect, and when possible, help to prevent regression. Activities shall encourage development or restoration to self-care and resumption of normal activities, stimulate and maximize the total functional ability of the resident and assist the resident to integrate into the social life of the facility. Families and friends of the resident shall be encouraged to accompany the resident to activities.

(c) Outside community resources, such as the Commission for the Blind, Office of Education, Divisions of Developmental Disabilities and Vocational Rehabilitation shall be accessed to develop needs-specific activities. Community outreach shall be done to encourage community groups to participate in programs in the facility. Residents also shall be encouraged to participate in programs in the community.

(d) Resident activities staffing requirements are as follows:

1. The resident activities director shall meet the qualifications required by N.J.A.C. 8:39-7, Mandatory Patient Activities. In a facility providing care exclusively to children, the resident activities director who does not possess a baccalaureate degree shall have one year of the required three years of experience in a recreational program for children.
2. The facility shall appoint a resident activities director who shall provide resident activity services in the facility on an average of 45 minutes per week per resident. Additional resident activity staff time shall be provided at a ratio of no less than 1:53 residents.
3. The use of volunteers should be encouraged as adjuncts to staff. Volunteers should be trained and supervised in the performance of their duties by qualified staff.

(e) Scheduling requirements are as follows:

1. A monthly schedule of activities in large print shall be conspicuously posted so that residents and staff are aware of daily programs.
2. There shall be a diversity of activities seven days per week and during at least two evenings per week. Evening activities shall be scheduled after the evening meal.
3. The Residents' Council shall have the opportunity to meet at least monthly. All residents shall be given the opportunity to have input

into programming.

(f) Space and equipment requirements are as follows:

1. Sufficient space shall be provided for group activities and for each resident's individual use. Activity areas shall be accessible to all residents. Programs shall be provided on the resident units as well as general activity areas.

2. Community social and recreational facilities shall be utilized for those able to do so. Transportation shall be provided to and from destinations in the community.

3. Adequate indoor and outdoor recreational areas shall be provided with sufficient equipment and materials available to support ongoing programs as well as self-directed activities.

4. In a facility providing care to children, a safe, handicapped accessible outdoor play area shall be provided.

(g) Resident planning requirements are as follows:

1. Activities staff shall be integral members of the interdisciplinary team and shall participate in all resident care conferences and quarterly reviews. Resident activities staff shall have input into the assessment.

2. Activities staff shall conduct an initial assessment of activity needs within 14 days after the date of admission. The assessment shall include the resident's current functioning, past lifestyle, interests, skills, employment, hobbies, organizational memberships, and religious preferences. This information shall form the basis for the activities component of the SRA.

3. The activities staff shall be aware of each resident's physical and medical limitations and restrictions, so that activities participation is coordinated with the treatment plan.

4. A plan for the resident's activities program shall be formulated, with the active participation of the resident, if possible. Resident goals shall be developed as an outcome of the SRA and in conjunction with the interdisciplinary care plan.

5. Progress towards goals shall be evaluated with the resident at least quarterly in conjunction with the interdisciplinary review of the care plan. If a resident's functional status changes, resident activity staff shall review the activity plan and make revisions of goals, if necessary.

6. Residents shall be encouraged to participate in a variety of activities. Outreach efforts to involve residents in activities programs shall be the responsibility of all staff.

7. All staff of the facility shall be trained at least yearly in the value of an activities program for overall effective resident care and shall encourage participation in activities.

8. On readmission after a period of hospitalization, an activities worker shall review the resident's functioning and shall participate in a reassessment, if a significant change has occurred.

10:63-2.6 Social services

(a) Social work services shall have as their fundamental purpose the enhancement of a resident's sense of well-being and control over his life to the fullest extent possible. Social work interventions shall be geared to the resident's strengths, regardless of the extent of disability and shall be designed to enhance coping skills. Social work services shall help residents make the fullest use of nursing facility life, and shall assist residents in discharge to community living.

(b) Social workers shall assist residents with the emotional reactions to pain and functional loss, interpersonal conflicts, fear of death, and other issues impacting on the quality of life. Supportive intervention and encouragement shall be provided. The social worker collaborates with other staff to maximize opportunities for choice and individual expression. Social workers shall monitor a resident's concrete and personal needs and shall serve as primary advocates for the resident in the NF.

(c) Social work services shall not include:

1. Clerical or billing activity;

2. Public relations activity that does not relate to social work services; or

3. Medical records monitoring responsibilities.

(d) Social services staffing and qualifications shall be as follows:

1. Social work services shall be provided in accordance with accepted professional practice by persons who meet the qualifications for social worker as defined in the Social Workers' Licensing Act of 1991 N.J.S.A. 45:15BB-1 et seq. and the licensure requirements of N.J.A.C. 8:39-39. In a NF providing care to children, it is recommended that social service staff receive consultation and training in social care for children.

2. The facility shall provide a minimum of one full-time equivalent social worker for every 120 residents. In a facility with more than 120 residents, one social worker shall coordinate the work of the department.

(e) Social services assessment and care planning shall be as follows:

1. The social worker shall meet with the resident and family prior to or following admission and shall conduct a social assessment. The social assessment shall be completed within 14 days of admission and shall provide the basis for social service input into the SRA. The assessment shall gather sufficient information to provide an accurate understanding of the individual and shall include the following:

   i. Current problem areas, factors that led to placement, and reactions to placement by the resident and family;

   ii. Lifestyle and living arrangements before placement;

   iii. Family composition, place of birth, marital history, number and location of children;

   iv. Social history, which includes personality factors, adaptation to change and disability, interest, religious ties, community activities, medical and psychiatric history, substance abuse; and

   v. Discharge criteria.

2. As an integral member of the interdisciplinary team, the social worker shall have active input into the completion of the Standardized Resident Assessment (SRA). The social worker shall attend resident care conferences and quarterly reviews.

3. Resident goals shall be developed as an outcome of the SRA and in conjunction with the interdisciplinary care plan. The resident and family shall be included in the development of goals if possible.

4. Reassessment of the resident's social needs shall be done annually in conjunction with the interdisciplinary team's review of the SRA. Any new social information shall be recorded in the progress notes.

5. Expectations regarding potential discharge shall be discussed fully with all residents and families on admission. The special needs of residents identified as only needing short term placement (Track II) during preadmission screening shall be discussed with the resident and family on admission. The family's criteria for discharge shall be fully explored and goals for discharge shall be incorporated into the interdisciplinary care plan.

6. Progress towards goals shall be reviewed with the interdisciplinary team quarterly, or when significant changes occur. Residents and families shall be included in the interdisciplinary care plan review, if possible. Goals shall be based on a current review of resident and family needs and the existing problems to be addressed, as reflected in the current SRA.

7. The social worker shall remain familiar enough with each resident to have an understanding of each resident's psycho-social function and to provide assistance as needed.

8. The social worker shall document important or unusual events and other circumstances which require social service intervention.

9. The record shall reflect the resident's current psycho-social functioning and social work interventions.

10. On readmission of a resident after a period of hospitalization, the social worker shall review the resident's functioning and participate in a reassessment if a significant change has occurred. If a new chart is opened on readmission, a copy of the original social assessment shall be included.

11. The resident's written consent (or that of a responsible person acting on his or her behalf) shall be obtained before social service information is transmitted to an outside agency or individual. The consent form shall be on the resident's chart. All personnel having access to the record shall be trained to appreciate its confidential nature.

(f) Social services consultation shall be as follows:

1. The social worker shall provide consultation services to residents and family members at the time of admission.

2. Consultation shall be given to the resident when the need arises, upon referral, or when the resident requests it. Situations which may require consultation include problems in adjusting to functional limitations and losses and decline in cognitive functioning involving loss of memory, confusion, and disorientation. Social work consultation may also be used to help residents deal with depression, anxiety, and lack of motivation and other problems affecting interpersonal relationships, such as aggressive or self-isolating behavior.

3. The social worker shall provide crisis intervention when medical or personal crises occur, or when there is a death of a family member or other significant person. Consultation shall also be offered when residents require assistance in mourning losses that occur within

the NF.

4. Social work intervention shall be provided when residents exhibit behavior problems, resistance to care, roommate conflicts, or other adjustment difficulties.

5. The social worker shall encourage residents to participate in their treatment plans and activities within and outside the facility, and to form satisfying and appropriate friendships with other individuals in the NF.

6. The social worker shall provide consultation to staff when interpersonal conflicts or behavior problems occur among residents or between residents and staff.

(g) Social work liaison services shall be as follows:

1. The social worker shall make frequent rounds in the NF, in order to maintain contact and to be accessible to residents who may require or be seeking assistance, and to maintain good communication with other staff.

2. Liaison contact with families shall be maintained by the social worker throughout a patient's stay. The frequency of contact shall depend on the resident's and family's needs.

3. The social worker shall be active in interpreting facility policies and procedures to the resident and his family during the initial period following admission. Questions, problems and complaints shall be addressed promptly.

4. The social worker shall act on a physician's order for a social service consultation within two working days.

5. The social worker shall assist in identifying residents who may be in need of psychological or psychiatric intervention.

6. The social worker shall assist staff in understanding the resident's personal situation and background in order to enhance the ability of staff to deal with the resident appropriately.

7. The social worker shall deal with problems concerning family visitation and support.

8. The social worker shall serve as a resource to assist families with social service needs and to locate other agencies for assistance.

(h) Social work supportive services shall be as follows:

1. The social worker shall ensure that the resident has sufficient

clothing and other personal items and that the resident's basic needs are being met.

2. The social worker shall ensure that the resident's rights are protected and that the Personal Needs Allowance (PNA) is properly utilized.

3. The social worker shall assist residents in understanding and exercising their rights, including the right to make health care decisions.

4. The social worker shall assist the resident in obtaining needed entitlements, community, or legal services.

5. The social worker shall facilitate the acquisition of prosthetic and assistive devices if necessary.

6. The social worker shall assist the resident and/or family in applying for Medicaid benefits, when appropriate.

7. The social worker shall work with the Activities and/or Volunteer Services Departments to obtain visitors for residents who have no supportive family or are otherwise isolated, or who have communication difficulties due to a language barrier.

8. The social worker may develop support and education groups for residents and families, as appropriate. The social worker shall serve as coordinator or co-coordinator in family support groups held in the NF and shall participate actively in meetings of the Resident's Council.

(i) Social services discharge planning shall be as follows;

1. The social worker shall be the primary staff member responsible for coordinating and carrying out discharge planning.

2. Discharge planning is a process that begins on admission and continues throughout the resident's stay until discharge occurs or is no longer feasible. Discharge planning shall be a collaborative effort by the entire interdisciplinary team. The social worker shall work very closely with nursing staff and other therapists until discharge is accomplished.

3. All residents shall have the right to live in the least restrictive setting possible. The social worker shall, in concert with other members of the interdisciplinary team, identify residents who may have discharge potential.

4. The social worker shall consult the HSDP on admission to determine the recommendations of the Medicaid RSN concerning

discharge and to identify Track II residents.

5. All residents who appear to be appropriate for discharge shall have their needs reviewed. This review shall include physical and social functioning, medical needs in the community, current and potential supports, resources needed for community living, and psychological readiness for discharge.

6. Discharge planning shall be carried out by means of an interdisciplinary care plan that includes goals and time frames. Social work intervention geared towards discharge shall be recorded as interim notes. The discharge plan shall include:

    i. The level of functioning which needs to be achieved by the resident prior to discharge;

    ii. Housing needs: the availability of prior living arrangements and the type of future housing needed for successful discharge (for example, apartment, family home, rooming or boarding home, residential health care facility, foster home and/or shared housing);

    iii. Any informal support systems available to the resident;

    iv. Specific financial assistance needed by the recipient; and

    v. Specific community resources needed for care in the community (for example, meals-on-wheels, day-care and/or home health assistance).

7. The social worker shall link the resident to necessary community resources and shall follow up to verify that services have been implemented.

8. The social worker shall assist in identifying the family's training needs for resident care in order to implement a successful discharge plan.

9. The social worker shall maintain active contact with the resident, his family, and significant others to support their involvement with the discharge plan.

10. The social worker shall be acquainted with formal resources that are available in the community and shall maintain an up-to-date resource file.

(j) In a NF providing care to children, the social services department shall initiate contact with the local school district when a child is admitted. The social worker shall also continue to serve as the coordinator between the local school district and the NF to facilitate the best care for the child.

10:63-2.7 Pharmaceutical services; general

(a) Prescribed legend drugs shall be supplied to each individual resident by a licensed pharmacy. Legend drugs may be supplied to individual residents by other than a licensed pharmacy when dispensed by NF medical professional staff from an emergency drug box, or the like, supplied by the NF's contracted pharmacy provider. Nonlegend drugs, such as aspirin, milk of magnesia, etc., may be separately stocked in the drugroom or medication cart of the NF. This will permit the NF to maintain a supply of non-legend drugs to be administered as directed by the prescribing physician under the supervision of a NF professional staff in keeping with established stop order policies (see (b) below). Reimbursement for non-legend drugs (that is, drugs which by Federal law do not require a prescription) shall be included in the NF per diem rate.

1. The New Jersey Medicaid program shall not reimburse for Methadone when used for drug detoxification or addiction.

(b) "Stop orders" are internal policy regulations of the NF and unrelated to the New Jersey Medicaid program rules. Thus, such "stop orders" shall not supersede Program rules concerning the prescribing of drugs and pharmaceutical services as outlined in N.J.A.C. 10:61, Pharmacy Services.

(c) In NFs, if the quantity of drug or medication is not indicated in writing by the prescriber, the pharmacy provider shall dispense an appropriate quantity of medication not to exceed a one month supply.

1. In NFs, a written physician order shall be considered a prescription. A physician order written to continue medication administration shall be considered a new prescription and issued a unique prescription number by the NF contracted pharmacy provider.

(d) Pharmacies with Institutional Permits shall be reimbursed pro-rated capitation which shall equal 75 percent of the capitation rate approved by Medicaid for pharmacies with Retail Permits.

(e) Signed physicians' orders for medications, drugs, tests, diet, and treatment administered to Medicaid recipients must be accurately recorded on the recipient's chart with review and update as required.

(f) All services required of a Consultant Pharmacist in NFs, as stipulated in Federal and State statutes, rules and regulations, including, but not limited to, those listed in this subsection shall be provided.

1. Responsibilities of the consultant pharmacist shall be as follows:
    i. Assure that all drugs are dispensed, and in cooperation with the Director of Nursing, shall assure all drugs are

administered in compliance with all State and Federal laws;

ii. Establish and monitor the implementation of written policies and procedures, through the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), to assure the safe use, storage, integrity, administration, control and accountability of drugs;

iii. Assure the drug records are in order and that an account of all controlled substances is maintained and reconciled;

iv. Assure that recipients' medication records are accurate, up to date, and that these records indicate that medications are administered in accordance with physician's orders and established stop-order policies;

v. Assure that drugs, biologicals, laboratory tests, special dietary requirements and foods, used or administered concomitantly with other medication to the same recipient, are monitored for potential adverse reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications, and that the physician is advised promptly of any recommended changes;

vi. Review the drug regimen (that is, the dosage form, route of administration and time of administration) of each recipient at least monthly and report any irregularities pertaining to medications to the attending physician, Medical Director or Director of Nursing, as appropriate. Irregularities in the administration of medications shall also be reported promptly to the Director of Nursing.

vii. Report in writing at least quarterly to the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), on the status of the facility's pharmaceutical services and staff performance as related to pharmaceutical services. This report shall include, but not be limited to, a summary of the review of each recipient's drug regimen and clinical record and the consultant pharmacist's findings and recommendations;

viii. Assure there is maintained and available upon request of the Director of the New Jersey Medicaid program or his or her designee, documented records of the disposition, disposal or destruction of unused or discontinued drugs;

ix. Serve as an active member of the Pharmaceutical Services Committee (Pharmacy and Therapeutics Committee), and Infection Control Committee of the facility;

x. Provide and document in-service programs for the complete nursing staff. This training shall include, but not be limited to, registered nurses, licensed practical nurses, and aides and shall be given at least quarterly; and

xi. Devote a sufficient number of hours to carry out these responsibilities, maintain a written record of activities, findings and recommendations.

10:63-2.8 Consultations and referrals for examination and treatment

(a) Certain services, such as medical and surgical specialties, chiropractic, dental, mental health, podiatric, and vision care, shall be initiated by the attending physician as either a request for a "consultation" or as a "referral for examination and treatment".

(b) A consultation shall be ordered when the attending physician wishes an appropriate practitioner to evaluate, through history and appropriate physical findings and other ancillary means:

1. The nature and progress of a disease, illness, or condition, and/or
2. To establish or confirm a diagnosis, and/or
3. To determine the prognosis, and/or
4. To suggest appropriate therapy.

(c) When a consultant assumes the continuing care of the resident, subsequent services rendered by the consultant are not considered a consultation and other appropriate procedure codes shall be utilized.

(d) A referral for examination and treatment shall be ordered by the attending physician when he or she wishes a practitioner to assume responsibility for a specific aspect of the resident's care; for example, the attending physician may order a referral for examination and treatment for dental services.

(e) For the initial consultation examination and subsequent examinations, the record shall document the following:

1. The date of service;
2. The chief complaint(s);
3. Pertinent historical and physical data;
4. Reports of diagnostic procedures performed;
5. The diagnosis; and

6. The treatment.

(f) A request for either a consultation or a referral for examination and treatment shall be written and signed by the attending physician on the order sheet, and shall clearly indicate the reason for the request.

1. If the attending physician is unable to write the request on the order sheet, he or she may personally dictate, by telephone to an appropriate person at the facility, the order for the consultation or the referral for examination and treatment, indicating the supporting reason(s) for the request. The attending physician shall then, within seven days of requesting the consultation or referral for examination and treatment, countersign the order on the order sheet or sign and forward to the NF an identical order on a prescription form which will satisfy the requirements until the next visit, when he or she shall sign the order sheet.

2. In consideration of a resident's rights, a resident may request either a consultation or a referral for examination and treatment, provided it is consistent with medical necessity. The attending physician shall note the request on the order sheet and, if the physician so wishes, may note that it was made at the resident's request.

Example: Resident requests ophthalmologic consultation with Dr. Evans for significant refractive error.

Signed: A.B. Turner, M.D.

10:63-2.9 Mental health services

(a) All facilities shall assist Medicaid recipients to obtain mental health care through a licensed psychiatrist or psychologist, who shall provide, or make provision for, routine and emergency services.

(b) An initial consultation for mental health services shall be performed only upon a written order signed by the attending physician (on the order sheet) citing the reason(s) for the consultation in the progress notes.

(c) If the mental health services are recommended following initial consultation, the psychiatrist or psychologist may provide the mental health service upon the written order signed by the attending physician. If the individual who provides the mental health services is a psychiatrist, he or she shall comply with the Medicaid policies cited in N.J.A.C. 10:54 regarding the request for authorization requirements for mental health services. If the individual who provides the mental health services is a psychologist, he or she shall comply with N.J.A.C. 10:67 regarding the request for authorization requirements for mental

health services.

(d) Therapeutic goals and outcomes shall be documented by the psychiatrist and/or psychologist in the clinical record and treatment provided only where there is potential for significant functional improvement within a reasonable time frame.

10:63-2.10 Dental services

(a) All facilities shall assist Medicaid recipients to obtain dental care through a licensed dentist, who shall provide, or make provision for:

1. Appropriate consulting services;
2. In-service education to the facility;
3. Policies concerning oral hygiene; and
4. Routine and emergency services.

(b) Dental examinations carried out to comply with the Department of Health's minimal requirements, as well as regular dental examinations, shall not be considered consultations and need not be brought to the attending physician's attention except as a matter of courtesy. However, treatments which involve invasive procedures such as extractions or fillings, except in an emergency, shall be brought to the attention of the attending physician who acknowledges clearance for such treatment on the order sheet.

(c) The dentist shall establish a time frame for the next periodic examination, either at the time of examination, or at the completion of treatment. The time frame entered on the clinical record may be for six months, one year, or any other time period that the attending dentist has established in accordance with his or her knowledge of the recipient.

(d) Dental care of a child residing in a NF shall be provided according to the American Dental Association Pediatric protocol available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60611.

(e) Policy and procedures regarding the provision of dental services are listed in the New Jersey Medicaid Program Manual for Dental Services. Services requiring prior authorization are listed under 202.2 (N.J.A.C. 10:56-1.3).

10:63-2.11 Podiatry services

(a) All facilities shall assist Medicaid recipients to obtain podiatry care through a licensed podiatrist who shall provide, or make provision for:

1. Appropriate consulting services;

2. In-service education for the facility;

3. Policies concerning foot care; and

4. Routine and emergency services.

(b) Once the attending physician reviews the consultation and approves the treatment plan of the podiatrist, the physician shall not be required to sign a request every time the podiatrist treats the resident; however, the attending physician shall review and approve the need for the podiatric services for residents under treatment every six months, and if continuing service is indicated, complete a request for podiatric services for each resident under treatment at least once a year. This shall be accomplished by an order on the order sheet and not by repeated requests for consultation.

1. Podiatry services provided to children shall be prior authorized by MDO professional staff.

(c) Policies and procedures regarding the provision of podiatric services are outlined in the New Jersey Medicaid Program's Podiatry Services Manual (N.J.A.C. 10:57).

10:63-2.12 Chiropractic services

All facilities shall assist Medicaid recipients to obtain chiropractic care through a licensed chiropractor who shall provide, or make provision for routine and emergency services.

10:63-2.13 Vision care services

(a) All facilities shall assist Medicaid recipients to obtain vision care through a licensed ophthalmologist or optometrist who shall provide, or make provision for, routine and emergency services.

(b) Policies and procedures regarding the provision of Vision Care services are outlined in the New Jersey Medicaid Program's Vision Care Manual (N.J.A.C. 10:62).

10:63-2.14 Laboratory; X-ray, portable X-ray and other diagnostic services

(a) A NF shall have written agreements with one or more general hospitals or one or more clinical laboratories so that the facility can obtain laboratory services, including emergency services promptly. If the facility has its own laboratory capabilities, the services may not be billed on a separate fee-for-service basis. A laboratory must be:

1. Licensed and/or approved by the New Jersey State Department of Health and the State Board of Medical Examiners which includes meeting Certificate of Need and licensure requirements, when required, and all applicable laboratory provisions of the New Jersey Sanitary Code; and

2. Certified as an independent laboratory under the Title XVIII Medicare Program; and

3. Approved for participation as an independent laboratory provider by the New Jersey Medicaid program.

(b) A NF shall have written agreements with one or more general hospitals or one or more Board certified or Board eligible radiologists so that the facility can obtain radiological services, including emergency services promptly.

1. Portable X-ray may be used when medically indicated. The mechanical portion of the services (obtaining the films) may be done by personnel of either the hospital or radiologist, but the interpretation of the film will be by a Board certified or Board eligible radiologist only.

2. X-ray services offered directly by the facility must be in adherence with the standards of the New Jersey Radiological Society.

(c) A NF shall have written agreements with one or more general hospitals or one or more qualified providers so that the facility can obtain other diagnostic services, such as ECG, EEG, CAT scan, MRI and ultrasonogram, including emergency services, promptly.

1. All diagnostic services shall be ordered by a physician, who shall be promptly notified of the test results.

2. All findings and reports shall be recorded in the recipients clinical record.

10:63-2.15 Medical supplies and equipment

(a) Medical supplies include incontinency pads, bandages, dressings, compresses, sponges, plasters, tapes, cellu-cotton or other types of pads used to save labor or linen, and other disposable items (for example, colostomy bags), hot water bags, thermometers, catheters, rubber gloves, and supplies required in the administration of medication including disposable syringes. Routinely used medical supplies are considered part of the institution's cost and cannot be billed directly to the program by the supplier.

(b) Equipment for administration of oxygen for residents in a NF is a required

service. Oxygen itself must conform to United States Pharmacopoeia Standards in order to be used as a medicinal gas. (United States Pharmacopoeia Convention, 12601 Twinbrook Parkway, Rockville, MD 20852.)

(c) Routinely used durable medical equipment ordered for Medicaid recipients in a participating NF (for example, walkers, wheelchairs, bed-rails, crutches, traction apparatus, IPPB machine, electric nebulizers, electric aspirators, low-end pressure relief systems such as mattress overlays and mattress replacements, powered mattress systems and powered flotation beds) and other therapeutic equipment and supplies essential to furnish the services offered by the facility for the care and treatment of its residents shall be considered part of the NF's cost, and shall not be billed directly to the program by the supplier.

(d) When unusual circumstances require special medical equipment not usually found in a NF, such special equipment may be reimbursable, with prior authorization from the Medicaid District Office serving the county where the facility is located.

1. When special medical equipment is authorized and purchased on behalf of a Medicaid recipient, ownership of such equipment shall vest in the Division of Medical Assistance and Health Services. The recipient shall be granted a possessory interest for as long as the recipient requires use of the equipment. When the recipient no longer needs such equipment, possession and control shall revert to the Division. The recipient shall agree to this when he or she signs the "patient's certification" section on the claim form. The NF shall notify the MDO in writing when such equipment is no longer in use.

2. Prior authorization requests for special medical equipment shall be accompanied by documentation from the attending physician, the registered professional nurse who has primary responsibility for the recipient, and appropriate rehabilitative therapy personnel, which relates the medical necessity for the equipment and describes the extraordinary requirements of the recipient.

3. Pressure relief systems shall be reimbursed in a NF under the following conditions:

    i. Air Fluidized and Low Air Loss therapy beds, as defined in N.J.A.C. 10:63-1.2, shall be considered special medical equipment and shall be prior authorized for reimbursement in a NF only when all of the following criteria, indicating medical necessity, are documented by the physician.

        (1) The recipient has two stage III (full-thickness tissue loss) pressure sores or a stage IV (deep tissue destruction) pressure sore which involves two of the

following sites: hips, buttocks, sacrum.

(2) The recipient with coexisting risk factors (such as vascular irregularities, nutritional depletion, diabetes or immune suppression) presents post-operatively with a posterior or lateral flap or graft site requiring short-term therapy until the operative site is viable.

(3) The recipient is bedridden or chair-bound as a result of severely limited mobility.

(4) The recipient is receiving maximal medical/nursing care, prior instituted conservative treatment has been unsuccessful and all other alternative equipment has been considered and ruled out.

(5) The bed is ordered, in writing, by the attending physician based on his or her comprehensive assessment (which includes a physical examination) and evaluation of the recipient.

(6) Prior authorization in conditions other than those defined above shall be considered on an individual basis by the MDO.

ii. Air fluidized and low air loss therapy beds shall not be covered for reimbursement in a NF under any of the following circumstances:

(1) As a preventative measure;

(2) After healing to stage II has occurred or wound stability (no significant change or evidence of healing) has been achieved;

(3) If the facility structure cannot support the weight of the bed or the facility electrical system is insufficient for the anticipated increase in energy consumption, air fluidized therapy shall be considered inappropriate. Reimbursement for an air fluidized bed shall be limited to the equipment itself. Payment shall not be made for architectural adjustments such as electrical or structural improvement.

iii. Prior authorization of air fluidized or low air loss therapy beds, if approved, shall be granted for 30 days only. Continued use beyond the initial approval period shall require prior authorization on a monthly basis. The following information shall be submitted to the MDO to obtain prior authorization:

(1) A completed FD-354 prior authorization form;

(2) The physicians' written prescription;

(3) A medical history relating to the wound which includes previous therapy and pressure relief systems utilized and found unsuccessful;

(4) Physician progress notes indicating medical necessity, plan of treatment and evaluation of response to treatment specific to the care of the wound;

(5) The wound care flow sheet documenting weekly the site, size, depth and stage of the wound, noting also the presence and description of drainage or odor;

(6) Laboratory values including a complete blood count and blood chemistries initially and on request thereafter;

(7) A nutritional assessment by a registered dietitian initially on request thereafter; and

(8) Photographs of the site upon permission of the recipient/family, after full due consideration is afforded to the recipient's right to privacy, dignity and confidentiality.

iv. After treatment with an air fluidized or low air loss therapy bed is initiated, the recipient shall:

(1) Be examined by the physician on a monthly basis;

(2) Remain on the therapy unit and be confined to bed, unless medically necessary. While confined to bed, due consideration shall be given to the recipient's need for social and sensory stimulation and recreational diversion by providing in-room visitation and social/recreational activities appropriate to the recipient's condition; and

(3) Be repositioned on a turning schedule of not less than every two hours.

v. Professional staff from the MDO may, at their discretion, perform an onsite visit to evaluate the recipient prior to or after therapy has been instituted. Continued approval shall be contingent upon the facility's compliance with the criteria and conditions defined in (d)3i, ii, iii and iv above and cooperation of the recipient to the therapeutic modality.

10:63-2.16 Consultant services; general

If the NF has significant, unresolved or recurring problems, the NF shall be required to provide appropriate consultation in any service area until the problems are corrected.

10:63-2.17 Transportation services

(a) The NF shall assist a Medicaid recipient in obtaining transportation when the recipient requires a Medicaid-covered service or care not regularly provided by the NF.

(b) If a transportation service is provided by the NF to an inpatient of the NF, no additional reimbursement shall be allowed. Reimbursement shall be included in the per diem rate.

(c) Ambulance service shall not require authorization from the MDO, but shall be reimbursable to the transportation provider only when the use of any other method of transportation is medically contraindicated. (See N.J.A.C. 10:50-1.3(c)2 for specific conditions for ambulance service reimbursement.)

(d) Invalid coach services shall not require prior authorization from the MDO.

1. Invalid coach services shall be provided by a transportation provider approved in accordance with N.J.A.C. 10:50, Transportation Services.
2. An invalid coach may be utilized when a Medicaid recipient requires transportation from place to place for the purpose of obtaining a Medicaid-covered service and when the use of an alternative mode of transportation, such as a taxi, bus, livery, or private vehicle would create a serious risk to life or health.

(e) Transportation by taxi, train, bus and other public conveyances shall not be directly reimbursable by the New Jersey Medicaid program. Inquiry should be made to the County Welfare Agency for authorization and payment for such transportation.

(f) Policy and procedures regarding the provision of transportation services are outlined in the New Jersey Medical Transportation Services Manual (N.J.A.C. 10:50-1.3 through 1.6).

10:63-2.18 Bed and board

(a) Beds are provided in rooms licensed by the New Jersey Department of Health. A NF providing care to children shall have available protective cribs for

infants and small children, as well as appropriate furniture, sized and scaled for children.

(b) Board shall be provided to meet basic nutritional needs and shall include the provision of therapeutic diets as prescribed by the attending physician.

10:63-2.19 Housekeeping and maintenance services

(a) Housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment and laundering of personal clothing (excluding dry cleaning) shall be required.

10:63-2.20 Non-covered services

(a) Non-covered services in NFs shall include, but not be limited to, the following:

1. Admission or continued care primarily for diet therapy of exogenous obesity, bed rest, rest cure, or care of non-medical nature;
2. Private duty nursing;
3. Private attendant services;
4. Services and supplies not related to the care of the resident, such as guest meals and accommodations, television, telephone, and personal items;
5. Practitioner or therapy services furnished on a fee for-service basis by an owner, partner, administrator, stockholder, or others having direct or indirect financial interest in the NF; or
6. Partial care services in independent clinics.

10:63-2.21 Special care nursing facility (SCNF)

(a) A special care nursing facility (SCNF) is a nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the Division of Medical Assistance and Health Services to provide care to New Jersey Medicaid recipients who require specialized nursing facility services beyond the scope of a conventional nursing facility as defined in N.J.A.C. 10:63-2. A SCNF or SCNF unit shall have a minimum of 24 beds.

1. The minimum bed requirement shall be waived for SCNFs that were approved by the Division prior to the adoption of this regulation. In addition, the requirement will be waived in those instances where a SCNF's Certificate of Need stipulates a specific number of beds approved by the New Jersey Department of Health.

2. A SCNF shall provide intensive medical, nursing and psychosocial management to the seriously ill individual who has potential for measurable and consistent maturation or rehabilitation, or has a technologically and/or therapeutically complex condition which requires the delivery of intensive and coordinated health care services on a 24 hour basis. Length of stay in a SCNF shall be determined by the individual's progress and the overall response to the therapeutic regimen.

(b) A SCNF shall provide the services of an interdisciplinary team, under the direction of a physician specialist, who has training and expertise in the treatment specific to the medical condition and specialized needs of the target population of the SCNF.

1. Within a focused, specialized therapeutic program, targeted, when appropriate, at timely discharge to alternative health care settings, such as conventional NF or community-based services, the SCNF shall provide:
   i. Aggressive management and treatment to stabilize, improve and monitor current conditions;
   ii. Appropriate, intensive rehabilitative therapies and counseling services; and
   iii. Coordinated care planning and delivery of required services.

(c) A SCNF shall provide services to Medicaid recipients who have been determined, through the PAS process, to require extended rehabilitation and/or complex care.

1. Extended rehabilitation shall be considered for a medically stable individual with a condition whose prognosis indicates the potential for rehabilitative progress which requires a prescribed period of therapeutic treatment and goal-directed services provided by a qualified interdisciplinary team to restore the individual to the highest practical level of physical, cognitive and behavioral functioning. The individual may remain for a period of up to 12 months, with a review after six months. Length of stay will be extended for periods of six months, if continued benefit from the service can be demonstrated.
2. Complex care shall be considered for a medically stable individual judged to have plateaued who demonstrates the need for prolonged, technologically and/or therapeutically complex care. Although the rehabilitative component may be less intense, the individual continues to require focused assessment, coordinated care planning and direct services on a continuing basis provided by

a interdisciplinary team with training and expertise in the treatment of the medical conditions and specialized needs of the resident population of the SCNF. The individual may remain for a period of up to 2 years with review every 12 months. Length of stay will be extended for periods of six months if continued benefit from the service can be demonstrated.

3. Medicaid recipients who are suitably placed in the community, receiving care in appropriate alternative placements or referred for social reasons only shall not be authorized for admission to a SCNF.

(d) Discharge procedures shall include utilizing Medicaid discharge protocols established by N.J.A.C. 10:63, and the following:

1. The recipient shall be discharged upon achievement of maximum benefit from the specialized programming and maximum level of functioning and when the individual's condition can be appropriately managed in either the community or other forms of institutional care.

2. Outpatient treatment and supported community services may be needed to assist in community integration.

3. In the case of a recipient residing in a SCNF unit of a conventional NF, who is determined by Division staff to no longer require special programming, yet continues to require conventional NF services, such a recipient shall be accepted for placement into a conventional NF bed in the facility. If a conventional NF bed within the facility is not available within a reasonable time, the SCNF shall assist the individual in finding placement in another facility. The SCNF shall be afforded 30 to 60 days from then date of the determination to effect transfer of the recipient to a bed within the facilities conventional bed allocation or arrange transfer to another conventional NF.

(e) The SCNF shall provide all required services, as defined in this subchapter.

1. A SCNF shall provide those medical services as defined in N.J.A.C. 10:63-2.3, with the following modifications and/or additions:

i. A free-standing SCNF shall have a designated medical director who is board eligible/certified in a medical specialty as targeted by the medical diagnoses, medical conditions and/or resident population of the SCNF. The medical director shall also function as a primary care attending physician. If a speciality medical group provides medical services to the

SCNF, a member of that group shall be designated as the medical director.

(1) In lieu of the requirements contained in i above, a free-standing SCNF may have a designated medical director who is a licensed physician and was serving as medical director prior to the effective date of these rules.

ii. For each resident there shall be a designated primary care physician specialist who is board eligible/certified in a medical specialty determined by the medical diagnoses, medical conditions and or resident population of the SCNF;

iii. Responsibilities of the primary care physician include but are not limited to:

(1) History, physical exam and diagnosis on admission and a comprehensive physical exam conducted on a yearly basis;

(2) Medical assessment shall reflect a correlation of the staging of existing diagnosis and premorbid conditions to the prognosis for rehabilitation.

(3) Each resident shall be examined and evaluated as required by the individual's condition as designated by the medical care plan.

2. A SCNF shall provide those nursing services as defined in N.J.A.C. 10:63-2.2 with the following modifications and/or additions:

i. A free-standing SCNF shall have a director of nurses or a nursing administrator who is a registered professional nurse in the State of New Jersey and possesses a Master's Degree or a Baccalaureate Degree in Nursing and has a minimum of two years experience as a nursing administrator or who has at least two years of supervisory experience in either an acute or longterm care setting.

(1) In lieu of (e)2i above, serve as director of nursing prior to the adoption of these regulations.

(2) A SCNF unit within a conventional NF whose director of nursing does not meet the qualifications of (e)2i above shall have a nurse manager who meets the qualifications assigned full time to the unit. The SCNF unit shall have six months from the date of adoption of these rules to comply with this requirement.

ii. Registered professional nurses certified in intravenous therapy shall be available on a 24 hour basis.

iii. Two and one-half hours of basic nursing services by registered professional nurses, licensed practical nurses and certified nurse aides as defined in N.J.A.C. 10:63-2.2. Additional nursing services up to a maximum of three hours may be provided due to technically complex nursing needs and/or intensive rehabilitative/restorative nursing care needs.

iv. Provision of additional nursing services (acuities) as defined in N.J.A.C. 10:63-2.2 does not apply to nurse staffing rules in a SCNF.

(1) Sixty percent of the additional hours of care under iii above shall be provided by registered professional nurses, and forty percent shall be provided by licensed practical nurses. There shall be a minimum of one registered professional nurse, one licensed practical nurse and one certified nurse aide on each shift.

v. Responsibilities of the nursing staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) Expertise and understanding of the physiologic impact, prognosis and treatment needs specific to the medical condition or specialized needs of the target population to enhance integration of the resident and family goals with adjustment and rehabilitation.

(2) Utilization and application of specialized equipment essential to provide services required for the care and treatment of the SCNF population.

(3) Comprehensive and coordinated program of restorative and rehabilitative nursing services to prevent complications and promote and/or restore the individual's physical, psychosocial function to a realistic level.

(4) Individual/family education and instruction of self care to promote optimum level of health in preparation for discharge to a less restrictive environment.

(5) Evaluation and management of moderate to extreme emotional and behavioral disorders related to illness.

3. A SCNF shall provide those social services as required by N.J.A.C. 10:63-2.6, with the following modifications and/or additions:

i. The social services coordinator shall possess a Master's Degree or Baccalaureate Degree in Social Work from a

college or university accredited by the Council on Social Work and have at least two years of full time social work experience in a health care setting.

ii. An average of at least 50 minutes of social work services per week for each resident. This is equal to one half-time equivalent social worker for every 24 residents.

iii. In a SCNF with more than 48 beds, one of the direct care social workers shall be designated as the Director of Social Services.

iv. Responsibilities of the social service staff, in concert with other members of the interdisciplinary team, include, but are not limited to:

(1) Knowledge of alternative care programs and resources in the community to assist the resident/family with appropriate discharge planning.

(2) Maintain a library of information and resources pertinent to the resident's diagnosis, educational/vocational training needs and applications to community based programs.

(3) Facilitate on-going collaboration and coordination among health care providers, the resident and the family to promote long-range social and health care planning.

(4) Coordinate SCNF programming with community-based resources to facilitate continuity of care and assimilation into community/family environment.

(5) On-going supportive intervention with the resident/family in dealing with the confusion, anger, fear, depression, guilt and conflict associated with illness.

4. A SCNF shall provide resident activities required by N.J.A.C. 10:63-2.5, with the following modifications and/or additions:

i. The director of resident activities shall possess a Master's Degree or Baccalaureate Degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, occupational therapy or therapeutic recreation. In addition, three years of experience in a clinical, residential or community-based therapeutic recreation program is required.

(1) In lieu of (e)4i above, serve as director of resident

activities prior to the adoption of these rules; or

(2) In lieu of (e)4i above, hold current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, 520 Stewart, Park Ridge, Illinois 60068) or the National Council of Therapeutic Recreation Certification (National Council of Therapeutic Recreation Certification, P.O. Box 16126, Alexandria, Virginia 22302.

ii. An average of at least 100 minutes of resident activity services per week for each resident. This is equal to one full-time equivalent resident activities staff for every 24 residents. This staff person shall serve as the Director of Resident Activities.

iii. For each additional 24 beds, the facility shall provide the services of a full-time resident activities assistant.

iv. Responsibilities of the resident activities staff, in concert with other members of the interdisciplinary team, shall include, but are not limited to:

(1) Utilization of all possible community, social, recreational, public and voluntary resources to promote the resident's ties with community life.

(2) Provision of therapeutic resident activities which endorse the therapeutic plan of care.

(3) Incorporation of family-centered activities which provide a supportive, therapeutic environment to give residents and families an opportunity to work together toward achieving common goals.

5. A SCNF shall provide, directly in the facility, the rehabilitation services as required by N.J.A.C. 10:63-2.4 on an intensive level which are specifically targeted to meet the goals of the prescribed treatment plan.

i. Rehabilitative therapies shall include, but shall not be limited to:

(1) Physical therapy;

(2) Occupational therapy;

(3) Speech/language pathology; and

(4) Cognitive or remedial therapies (including neuropsychological treatment)

ii. Rehabilitation services shall focus on developing and/or restoring maximum levels of function within the limits of the resident's impairment. Through collaboration with other members of the interdisciplinary team, a comprehensive rehabilitation plan shall be developed which:

(1) Identifies rehabilitation needs and establishes realistic criteria for measuring the need for continued rehabilitative services;

(2) Projects targeted outcomes (goals) and defines the parameters to measure response to treatment goals; and

(3) Establishes realistic time frames to meet outcome criteria.

6. Mental health services provided by a licensed psychiatrist, psychologist or other appropriately credentialed professional shall be provided to residents with mental health disorders in accordance with N.J.A.C. 10:63-2.9.

7. A SCNF that provides ventilator management of New Jersey Medicaid eligible children or adults, shall provide respiratory therapy services beyond the scope of N.J.A.C. 10:63-2, which shall include, but not be limited to:

i. A respiratory care practitioner who is currently licensed by the New Jersey State Board of Respiratory Care be available on the premises on a 24 hour basis.

ii. Respiratory life support systems must be provided inclusive of, but not limited to:

(1) Mechanical ventilators (pressure/volume/time cycled), (portable/stationary); and

(2) Oxygen therapy delivery systems.

iii. Administration of medically prescribed respiratory care which includes, but is not limited to:

(1) Nasopharyngeal aspiration;

(2) Maintenance of natural and mechanical airways;

(3) Insertion and maintenance of artificial airways;

(4) Aerosol treatment;

(5) Administration of nebulized bronchodilators;

(6) IPPB;

(7) Oxygen therapy;

(8) Mechanical ventilation with/without supplemental oxygen;

(9) Monitoring of blood gases;

(10) Under the direction of the pulmonologist, the respiratory therapist applies weaning parameters and provides direct supervision during the weaning process;

(11) Postural drainage and chest percussion; and

(12) Breathing exercise and respiratory rehabilitation.

iv. Medically prescribed respiratory therapy may be provided to non-ventilator dependent children or adults who, due to cardio-respiratory deficiencies and/or abnormalities, require:

(1) Apparatus for cardio-respiratory support and control;

(2) Respiratory rehabilitation/chest physiotherapy;

(3) Maintenance of natural airway patency;

(4) Insertion and maintenance of artificial airway;

(5) Measurement of cardio-respiratory volume, pressure and flow;

(6) Drawing and analyzing samples of arterial, capillary and venous blood; and/or

(7) Administration of aerosolized respiratory medications such as nebulized bronchodilators or antiprotozoals.

SUBCHAPTER 3. COST STUDY, RATE REVIEW GUIDELINES AND REPORTING SYSTEM FOR LONG-TERM CARE FACILITIES

10:63-3.1 Purpose and scope

(a) These rules describe the methodology to be used by the State of New Jersey to establish prospective per diem rates for the provision of nursing facility services to residents under the State's Medicaid program. These rules have been developed jointly by the State Department of Human Services and the State Department of Health ("the departments").

(b) The departments believe that the strict application of these rules will generally produce equitable rates for the payment of nursing facilities (NFs) for the reasonable cost of providing routine patient care services. The departments recognize, however, that no rules can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

(c) Accordingly, in the case where a NF believes that, owing to an unusual situation, the application of these rules results in an inequity, the departments are prepared to review the particular circumstances with the NF. Appeals on the grounds of inequity should be limited to circumstances peculiar to the NF affected. They should not address the broader aspects of the rules themselves.

(d) On the other hand, these rules are not purported to be an exhaustive list of unreasonable costs. Accordingly, notwithstanding any inference one may derive from these guidelines, the departments reserve the right to question and exclude from any unreasonable costs, consistent with the provision of N.J.S.A. 30:4D-1 et seq.

(e) All rates established pursuant to these rules will be subject to onsite audit verification of costs and statistics reported by NFs.

(f) The nursing facility reimbursement formulae contained in this subchapter have been developed to meet the following overall goals:

1. To comply with Federal requirements that rates are reasonable and adequate to meet the cost that efficiently and economically operated facilities must incur to provide care in conformity with applicable State and Federal laws, rules, regulations and quality and safety standards.
2. To provide sufficient incentive to attract nursing facility investment, thereby reducing the reported Medicaid bed shortage; and
3. To end opportunities for excessive property cost reimbursement.

10:63-3.2 Timing

(a) Commencing with fiscal year ending with November 30, 1977, NFs shall furnish required cost studies to the Department of Health, Health Facilities Rate Setting within 90 days of the close of each fiscal year. For rate review purposes, the period for which these actual data are reported will constitute the "base period" for establishing prospective per diem reimbursement rates commencing six months after the end of the base period. These rates will not be subject to routine retroactive adjustments except for matters specified in this subchapter. As required by Federal regulations at 42 CFR 447.304, prospectively determined payment rates will be redetermined at least annually.

(b) Where cost studies, and other required documents, are received beyond the 90 day filing requirements, the following schedule of penalties will be applied to current and/or subsequent reimbursement rates as the particular circumstances dictate:

Number of days After due date	Amount of Penalty	Month(s) of penalty
1-15	$ .25 per patient day	1st month
16-30	$ .50 per patient day	1st month
31-60	$ .50 per patient day	1st month
	$1.00 per patient day	2nd month
61-90	$ .50 per patient day	1st month
	$1.00 per patient day	2nd month
	$2.00 per patient day	3rd month
91 and	$ .50 per patient day	1st month
thereafter	$1.00 per patient day	2nd month
	$2.00 per patient day	3rd month
	$3.00 per patient day	4th and subsequent
		months

(c) Penalties will remain in force until such time that a cost report and other required documents, completed in accordance with "Care" guidelines, have been received. Penalties are not recoverable and are not allowable costs.

(d) The Director, Division of Medical Assistance and Health Services, or a designee of the Director, may mitigate or waive the penalties specified in (b) above, for "good cause" shown:

1. "Good cause" shall include but shall not be limited to, circumstances beyond the control of the nursing care facility, such as fire, flood or other natural disaster;
2. Acts of omission and/or negligence by the nursing facility, its employees, or its agents, shall not constitute "good cause" for

waiving the penalty provisions;

3. All requests for mitigation and/or waiver of the penalty provisions must be submitted in writing, and accompanied by such documentation and/or supporting affidavits as the Director may require.

(e) The penalty rates indicated in (b) above will be applied to cost studies commencing with the reporting periods ending May 1, 1980.

(f) A nursing facility cost report cannot be substituted or revised by a NF except during the 30 calendar days after the original due date of the cost report to the Department of Health, Health Facilities Rate Setting. However, such substitution or revision can be made if it would prevent an overpayment to the NF.

10:63-3.3 Rate components

(a) The prospective rates will be "screened" rates per day calculated by applying standards and reasonableness criteria ("screens") for three classes of NFs:

1. Class I Proprietary and Voluntary NFs:

2. Class II Governmental NFs:

   i. To qualify as a Class II Governmental NF, the NF shall meet all of the contractual requirements of the Division of Medical Assistance and Health Services and be a governmental operation.

3. Class III (Special Care) Nursing Facilities (SCNFs)

   i. To qualify as a SCNF, the NF shall meet all of the contractual requirements of the Division of Medical Assistance and Health Services and be approved by the Division as a SCNF.

   ii. SCNFs shall be grouped by the following types for separate screening purposes:

      (1) Ventilator/Respirator;

      (2) TBI/Coma;

      (3) Pediatric;

      (4) HIV;

      (5) Neurologically Impaired (NIP); and

      (6) Behavioral Management.

(b) The "screens" will be applied to the following five rate components as identified on reporting Schedule A:

1. Raw Food Costs;
2. General Service Expenses;
3. Property-Operating Costs;
4. Patient Care Expenses;
5. Property-Capital Costs (including return on investment).

(c) Reimbursement for therapy services will be made as follows:

1. For Class I and II programs, reimbursement will be made for physical, speech, and occupational therapy services to Medicaid patients for treatments which are not reimbursable by any other third party payor.
    i. A per diem will be calculated for each facility by multiplying the number of otherwise reimbursable base period Medicaid patient therapy sessions by $7.00 and dividing the product by the total number of base period Medicaid patient days.
2. For Class III programs, all therapy costs for other than respiratory therapy will be reimbursed by a per diem calculated by dividing total base period therapy costs for Medicaid patients (less recoveries for medicaid patients) by total base period Medicaid patient days for each facility.
3. Respiratory therapist services (salary, fringes and/or fees) will be reimbursed to all Class III programs by dividing base period respiratory therapist salary, fringes and/or fees for respiratory therapist services, by total actual base period patient days.

(d) The development of the “screens” for Class I, Class II, and Class III NFs includes the governemental NFs’ and SCNFs’ reported costs and statistics in the following areas:

1. Administrator;
2. Assistant administrator;
3. Median days per bed.

(e) Administrator and assistant administrator screens determined by (d)

above, for NFs which combine Class I or Class II, and Class III programs will be allocated in the ratio of applicable (that is, Class I or Class II or Class III) patient days to the total NF patient days.

(f) The screen for each cost component of a Class III NF administered by a governmental facility will be the screen established for the Class III NF and not the Class II governmental screen.

(g) A provision for inflation will be added to reasonable base period costs in calculating the prospective rates as described in N.J.A.C. 10:63-3.19.

(h) All lease costs incurred as a result of related party transactions, will be excluded for reimbursement purposes.

1. A "related party" is defined in the "CARE" guidelines under Schedule F as:

   i. A corporation, partnership, trust or other business entity:

      (1) Which has an equity interest of 10 percent or more of the facility;

      (2) Which has an equity interest of 10 percent or more in any business entity which is related by the definition in (h)1i(1) above or which has an equity interest of 10 percent or more in any business entity related by (h)i(2) of this section; or

      (3) In which any party who is a related party by any other definition (above or below) has an equity interest of 10 percent or more and which has a significant business relationship with the home.

   ii. An individual:

      (1) Who has a beneficial interest of 10 percent or more in the net worth of the home; or

      (2) Who has a beneficial interest of 10 percent or more in an entity related by (h)1i(2) or (3) above; or

      (3) Who is a relative of an individual who is related by the definition in (h)1ii(1) or (2) above;

      (4) Beneficial interest is cumulative, if it relates to spouse, parent or children.

(i) In related lease transactions, the rent paid to the lessor by the provider is not allowable as cost. The provider, however, would include in its costs the property expenses of ownership of the facility. The effect is to treat the facility as

though it were owned by the provider. The treatment of these non-allowable costs is consistent with Federal regulations as they apply to costs to related organizations.

(j) Any legal expenses and related fees associated with any action initiated by the facility that is dismissed on the basis that no reasonable ground existed for the institution of such action will be excluded for reimbursement purposes.

(k) The cost of legal services for the appeal of reimbursement rates shall be excluded for reimbursement purposes.

10:63-3.4 Equalized costs

(a) In order to equitably develop and apply screens the following computation will be made:

1. General fringe benefits will be allocated to function as a percentage of salaries reported to develop total compensation. General fringe benefits will include the raw food value of free and subsidized meals to employees.
2. Costs will be equalized to adjust for timing differences among NF's fiscal years.
3. The term "equalized costs" means the net amount of compensation costs (salary and fringe benefits) plus other expenses, less expense recoveries and nonallowable costs, adjusted for timing differences among NF's fiscal years.
4. For NFs which provide residential, sheltered or domiciliary care, equalized nursing facility costs will be determined by apportioning equalized cost in the same ratio as the apportionment of unequalized net expenses.
5. The equalized net routine expenses will be apportioned to residential/sheltered care and nursing facility care in the same ratio as unequalized net routine expenses are apportioned, except in the case of land and building related items (see sections 6 and 10, of this subchapter).
6. In the calculation of costs screens, the per diem median runs and the cost regression analysis for the administrator/management screen will be calculated using actual patient days excluding bed hold days.

10:63-3.5 Raw food costs

(a) Raw food costs per patient day for voluntary and proprietary NFs which

provide their own food service and which had over 20 percent Medicaid patient days in the base period will be determined. NFs which contract for their dietary operations will be excluded. These per diem costs will be ranked in descending order on a Statewide basis. The reasonableness limit will be set at 120 percent of the median cost per day.

1. Governmental NFs which provide their own food service and which had over 20 percent Medicaid patient days in the base period will be ranked separately and the reasonableness limit will be set at 120 percent of their median cost per day.
2. SCNFs which provide their own food service will be ranked separately for each type of Class III NF and a reasonableness limit for each type will be set at 120 percent of the median cost per day.

(b) For NFs below this limit, prospective rates will be based upon actual costs. Where homes report unit costs 15 percent or more below the median, the Department of Health, Health Facilities Inspection, will be asked to inspect the food operations for compliance with State standards.

(c) For NFs which exceed this reasonableness limit for raw food costs, a credit may be applied to offset the excess raw food costs if dietary/housekeeping/laundry and linen costs are below the reasonable limit established for dietary/housekeeping/laundry and linen costs. Any such credit shall not exceed the amount of the excess raw food cost.

10:63-3.6 General services expenses

(a) For purposes of screening reported base period costs, the general services category will be segregated into cost components and reasonableness limits shall be developed for each component of cost. For rates implemented on or after July 1, 1999, reimbursement rates shall include the lower of actual costs or reasonable limits developed for each component. The cost components shall include:

1. Food;
2. Administrator;
3. Assistant administrator;
4. Other administrative services;
5. Dietary/housekeeping/laundry and linen; and
6. Other general services.

(b) The bases for screen development and reported costs subject to

applicable screens, are as follows:

1. Food: As indicated in N.J.A.C. 10:63-3.5.

2. Administrator: Reasonable compensation of unrelated administrators as determined by the regression analysis formula utilized by the Department of Health and Senior Services Nursing Facility and Reimbursement.

    i. The regression will utilize as variables: fringed salaries of unrelated administrators and facility bed size. The constants resulting from the regression formula will then be used in the following formula, effective July 1, 1996, to produce reasonableness limits for each long term care provider.

[x + (y/median days per bed x NF patient days)] x 1.0 = Limit

x = Salary constant from regression
Y = per bed salary constant from regression

    ii. The administrator screen will be applied to the aggregate reported costs of management, administrator, and assistant administrator, for facilities with less than 100 licensed nursing facility beds.

    iii. Compensation and special fringe benefits of all owners, officers, related parties, and other employees acting in an administrative capacity must be reported as Management unless such parties specifically carry out the function of Administrator or Assistant Administrator.

    iv. Non-working officer, owner or related party compensation and special fringe benefits are non-allowable.

3. Assistant Administrator: Effective July 1, 1996, limited to 100 percent of median unrelated assistant administrator compensation.

    i. This cost category will apply only to facilities which exceed 99 licensed nursing facility beds.

4. Reasonableness limits for the housekeeping/dietary/laundry and linen, other administrative services, and other general services categories will be established, effective July 1, 1996, at:

    i. 100 percent of median costs as reported by Class I facilities which had over 20 percent Medicaid patient days.

    ii. 100 percent of median costs as reported by Class II facilities which had over 20 percent Medicaid patient days.

iii. 100 percent of median costs for each type of Class III program reported by SCNFs.

(c) For NFs which exceed this reasonableness limit for dietary/housekeeping/laundry and linen costs, a credit may be applied to offset the excess dietary/housekeeping/laundry and linen costs, if costs are below the reasonable limit established for other administrative services and/or other general services costs. Any such credit shall not exceed the amount of the excess dietary/housekeeping/laundry and linen costs.

10:63-3.7 Property operating expenses

(a) Property operating expenses include property taxes and utilities.

1. Property taxes will be considered reasonable so long as they are based upon reasonable plant square feet, costs per square foot, and reasonable land area and value.

2. For this purpose, reasonable plant square feet (and related property taxes) is determined as follows:

i. The ratio of plant square feet to licensed beds is determined as follows:

(1) Reasonable plant square feet for Class I NFs is determined separately to be 367 square feet per bed as in (a)1 above.

(2) Reasonable plant square feet for Class II NFs is determined separately to be 635 square feet per bed as in (a)1 above.

(3) Reasonable plant square feet for Class III NFs is determined separately (using a 1994 base) to be 504 square feet per bed as in (a)1 above.

ii. This ratio will establish the base plant square feet for a NF with a given number of licensed beds.

iii. The reasonableness limit for each NF's plant square feet shall be established at 110 percent of the base for its licensed beds. (see N.J.A.C. 10:63-3.11 for NFs with residential or sheltered care patients).

3. For NFs whose plant square feet exceeds this limit, the property taxes related to the excess will be excluded from the rate base. For this purpose, it will be assumed that assessed values for buildings vary directly in relation to their areas. The latitude set forth in paragraph 2iii of this subsection is intended to provide for inequities

that could result from this assumption. The department will review on an individual basis, any additional inequities which owners believe are brought about by unusual circumstances.

4. For NFs whose appraised value per plant square foot (as determined by an agent designated by the State) is greater than 110 percent of the median construction costs at 1977 price levels, the property taxes attributable to the excess will be excluded from the rate base unless the owners can demonstrate unusual circumstances. For screening new NFs, this figure will be revised each year for inflation and for effects of standards changes upon construction cost. (See N.J.A.C. 10:63-3.11 for the methodology for calculating this limit at 1977 price levels.)

5. Reasonable land area (and related taxes) is established as follows:

   i. For urban NFs two acres;

   ii. For nonurban NFs five acres;

   iii. For this purpose, a city, town, and so forth is considered "urban" if its population exceeds 25,000 and its average population density exceeds 7,000 per square mile. All other areas are considered "nonurban" or rural.

6. Property taxes ascribable to unreasonable land area will be excluded from the prospective rate base, based upon the assumption that assessed values vary directly with area.

7. After making any adjustments per (a)6 above, taxes based upon land appraisals in excess of 140 percent of the median appraisal value of five acres, rural and two acres, urban of all NFs in the county will also be considered unreasonable. In the case of counties with fewer than five NFs neighboring counties may be combined in determining the median value to be used.

8. The department will review on an individual basis any inequities which owners believe are brought about by unusual circumstances.

(b) As noted in the instructions for the submission of cost studies, where a lessor is paying the property taxes, the actual property taxes paid by the lessor are to be reported by the NF operator as a property tax expense and deducted from the amount reported as rent. The property tax component of such leases will be subject to the above screens.

(c) Utility costs will be screened for reasonableness as follows:

1. Base period utility costs per bed will be deemed unreasonable to the extent that they exceed 125 percent of the Statewide median

cost per bed, as determined for each class type of NF indicated in N.J.A.C. 10:63-3.3.

i. The Department will upon request review any inequities which owners believe are brought about by unusual circumstances.

10:63-3.8 Special amortization

(a) The departments will consider on an individual basis, the amortization of start-up costs and special expenditures in rates. Each case will be reviewed on its particular merits and, accordingly, no guidelines are specified herein. As a rule, however, provisions for special amortization would relate to expenditures of a capital nature that are mandated by changes in laws and regulations. The amortization period would generally range from 12 to 60 months, depending upon the nature and magnitude of expenses.

(b) In approving the amortization of special expenditures, the departments will also consider the extent to which a NF's rates are based on capital and cost levels of fully complying NFs, or, for capital items, a review of a minimum of three bids on the acquisition or project.

10:63-3.9 Routine patient care expenses

(a) For reporting purposes (on schedule A) and for the application of the following guidelines, "routine patient care expenses" are defined as expenses relating to those services defined as includable in the per diem rates for routine care under the Medicaid program.

(b) Reasonableness limits for nursing services (RN's, LPN's and other) will be established as follows:

1. The minimum nursing requirements in terms of hours worked will be calculated for each Class I and Class II NF based upon the case mix patient classification (see N.J.A.C. 10:63-3.9(b)1ii(2) and standards in effect during the base period. Minimum nursing requirements in terms of hours shall be calculated for each NF based upon:

   i. The number of patient days during the base period;

   ii. The base period patient mix related to additional nursing services requiring additional minimum nursing time as derived from patient counts reported by each facility to the Medicaid fiscal agent:

      (1) Patients with conditions requiring additional nursing services will be reported by means of the billing

turnaround document (TAD) for Medicaid recipients, and the Medicaid billing certification document for non-Medicaid patients. If a facility fails to report a condition requiring additional nursing services on the original TAD or billing certification document, the count will not be used in the facility's rate calculation.

(2) Facilities will report patients with conditions requiring additional nursing services if a patient: resided in the facility and had the condition(s) for the entire month; resided in the facility for the entire month and developed the condition(s) during that month; or entered the facility and had the condition(s) for some portion of the month. This count shall include patients who develop condition(s) during a month or enter the facility with condition(s) and cease to have this condition, are discharged, or die during the same month. No reporting shall be made for a patient who ceased to have the condition(s), died or left the facility during a month (other than the month of admission or onset of the condition(s)), except for a patient who was on a bed hold leave to an acute care hospital and returned to the facility.

iii. The State Department of Health minimum nurse staffing standards, according to N.J.A.C. 8:39-25.

iv. If the calculation of the minimum nurse staffing requirement results in an amount of hours for each type of nurse (RNs, LPNs, and Aides) which includes some part of a full-time equivalent staff position (FTE at seven days per week), the minimum hours required for each type of nurse will be increased to include time sufficient to staff a full-time equivalent staff position (FTE at seven days per week).

2. The minimum nursing requirements in terms of hours worked will be calculated for each Class III program as follows:

i. A base of 2.5 hours per patient day (20 percent RNs and LPNs; 80 percent Aides);

ii. An additional three hours per patient day (60 percent RNs, 40 percent LPNs);

iii. The total minimum hours per year for each type of nurse will be at least 8,760 (that is, allowing staff of one RN, LPN and Aide on each shift.

3. The percentage of hours paid for vacations, holidays, illness, and so forth (hours paid but not worked) to hours worked, will be ranked

in descending order for all proprietary and voluntary NFs in the State. Separate rankings will be developed for governmental NFs and each type of SCNF. The percentage for the median NF for each class of facility will be selected as the Statewide norm for the percentage of hours paid but not worked for that class of facility.

4. The hours developed in (b)1i-iv and (b)2i-iii above will be incremented by the applicable percentage for each class of NF.

5. The average equalized hourly compensation rate of each type of nurse (see N.J.A.C. 10:63-3.4) will be calculated separately for Class I, Class II, and each type of Class III facility.

   i. The average equalized compensation rate for the median NF for each class/type of NF will be selected as the norm for the State.

6. The compensation rates for each class/type of facility will be multiplied by the paid hours developed in (b)4 above for each type of nurse and aggregated for all three types of nurses.

7. The reasonableness limit for total nursing care will be established at 115 percent of this total for Class I and Class II facilities and 125 percent of this total for Class III facilities, in order to allow for variations in staffing patterns, mix of nursing personnel, and so forth. This total will be adjusted for timing differences to each NF's base period.

(c) Reasonableness limits for the below listed special patient care services other than nursing will be established for each class of NF.

1. Those items which are considered special patient care services are:

   i. Medical Director;

   ii. Patient activities;

   iii. Pharmaceutical consultant;

   iv. Non-legend drugs;

   v. Medical supplies;

   vi. Social services;

   vii. Oxygen.

(d) Reasonableness limits for medical supplies and patient activities will be established at:

1. 150 percent of the median per diem cost of Class I NFs which had over 20 percent Medicaid days in the base period.

2. 150 percent of the median per diem cost of Class II NFs which had over 20 percent Medicaid days in the base period.

3. 150 percent of the median per diem cost for each type of Class III NF, excluding any facility without reported costs.

   i. For Class III NFs which are approved as a combination of ventilator/respirator type and some other SCNF type listed at N.J.A.C. 10:63-3.3(a)3ii, the reasonable limit for medical supplies will be determined by multiplying applicable patient days (ventilator patient days versus a non-ventilator/respirator SCNF-type patient days) times the appropriate medical supplies screen (ventilator versus a non-ventilator/respirator SCNF type) and adding the products, as follows:

	(1) Base period Patient Days	(2) Limit Per day	(3) Total (1) x (2)
Vent	A	C	E
Other	B	D	F
Total reasonable limit (E + F)			G

(e) Reasonableness limits for medical director, pharmaceutical consultant, non-legend drugs, social services and oxygen will be established at:

1. 110 percent of the median per diem cost of Class I NFs which had over over 20 percent Medicaid days in the base period.

2. 110 percent of the median per diem cost of Class II NFs which had over over 20 percent Medicaid days in the base period.

3. 110 percent of the median per diem cost for each type of Class III NF, excluding any facility without reported costs, except as provided in (e)3i and ii below:

   i. For freestanding SCNFs, a separate medical director screen will be calculated for each type of SCNF.

   ii. For Class III NFs which are approved as a combination of a Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. 10:63-3.3(a)3, reasonable limits for oxygen will be determined by multiplying applicable patient days (ventilator patient days versus a non-ventilator/respirator SCNF type patient days) times the appropriate oxygen screen (ventilator versus a non-ventilator/respirator type

SCNF) and adding the products, as follows:

	(1) Base period Patient Days	(2) Limit Per day	(3) Total (1) x (2)
Vent	A	C	E
Other	B	D	F
Total reasonable limit (E + F)			G

(f) Where actual base period costs for routine patient care are below the limits established, the actual costs will be included in the rate base. The Department of Health, Health Facilities Inspection, will be notified of all cases where a NF patient care costs per day are less than 75 percent of the limits in N.J.A.C. 10:63-3.8(b)6 and of all cases where nursing hours worked appear to be below State standards.

10:63-3.10 Property-capital costs

(a) Included in this category are the following rate components:

1. Depreciation (except autos);
2. Maintenance and replacement of plant and equipment;
3. Rentals of buildings and equipment (except autos);
4. Interest on all indebtedness;
5. Amortization of leasehold improvement;
6. Property insurance costs;
7. Fees and other expenses incurred in connection with the construction, purchase, alteration or leasing of land, buildings, and fixed equipment; and
8. Fees and other expenses incurred in financing or refinancing of the NF itself or any of its assets.

(b) The rules promulgated herein have been developed with the following objectives and considerations:

1. The departments should not concern themselves with the method and attendant costs with which individuals NFs are financed and constructed or the arrangements under which they are acquired or leased.
2. While not concerning themselves about the costs, financing and so forth, of individual NFs the departments mandate with respect to

the reasonableness of cost requires it to develop this rate component upon the presumption of reasonable facility costs and prudent financing.

3. Private capital should be attracted into the industry with a reasonable rate of return, which should recognize that the existence of the certificate of need process to control the supply of NFs in relation to demand, removes several risks inherent in most free enterprise situations.

(c) The departments believe that the above objectives can best be met by establishing an aggregate "capital facilities allowance" (CFA). The aggregate annual CFA for building, land, and movable equipment shall constitute the maximum reasonable reimbursement for depreciation (except automobiles), rentals of buildings and equipment (except automobiles), interest on all indebtedness, and amortization of leasehold improvements. Reimbursement shall be limited to the lower of:

1. The total actual NF expenses for depreciation, interest and rental; or
2. The aggregate capital facilities allowance for building, land, and movable equipment.

(d) The following considerations will be addressed in determining the CFA:

1. Buildings (see N.J.A.C. 10:63-3.11);
2. Land and land improvements (see N.J.A.C. 10:63-3.12);
3. Equipment (routine moveable) (see N.J.A.C. 10:63-3.13);
4. Maintenance and replacements (see N.J.A.C. 10:63-3.14);
5. Property insurance (see N.J.A.C. 10:63-3.15);
6. Economic occupancy level (see N.J.A.C. 10:63-3.16).

10:63-3.11 Buildings and fixed equipment

(a) The CFA for buildings and fixed equipment will be based upon appraised value as follows:

1. For NFs beginning operation before January 1, 1978, the CFA will be determined based upon appraised 1977 replacement costs derived from nationally recognized construction cost manuals, less wear and tear and subject to reasonableness limits as described in (c), (d) and (e) below.

2. For new NFs, replacement NFs, or significant additions to existing NFs, beginning operation on or after January 1, 1978, the appraised value will be determined at the time construction is completed, based upon price levels derived from nationally recognized construction cost manuals, subject to reasonableness limits as described in (c), (d) and (e) below.

(b) The appraisals are to be conducted by an agent designated by the State.

(c) A reasonableness limit on plant square feet will be set at 110 percent of the median plant square feet per available bed of all Class I and Class III NFs which had over 20 percent Medicaid patient days in the base period. A separate reasonableness limit will be developed for governmental Class II NFs by the same method. NFs not substantially complying with current State and Federal space requirements or carrying space waivers will be excluded from this calculation.

(d) The Department shall establish a reasonableness limit on the amount of reimbursement that an NF shall receive for the building and fixed equipment component of its CFA.

1. The reasonableness limits on appraised value per square foot set for NFs from 1977 through 2000 are as follows:

Year	Year Specific Factor Class I & III NFs	Year Specific Factor Class II NFs	Year	Year Specific Factor Class I & III NFs	Year Specific. Factor cLass II NFs
1977	$ 43.00	$ 50.00	1989	$ 109.00	$ 128.00
1978	$ 49.00	$ 57.00	1990	$ 114.00	$ 133.00
1979	$ 54.00	$ 63.00	1991	$ 119.00	$ 139.00
1980	$ 59.00	$ 69.00	1992	$ 123.00	$ 144.00
1981	$ 65.00	$ 76.00	1993	$ 128.00	$ 150.00
1982	$ 72.00	$ 84.00	1994	$ 133.00	$ 156.00
1983	$ 79.00	$ 92.00	1995	$ 138.00	$ 162.00
1984	$ 87.00	$101.00	1996	$ 143.00	$ 168.00
1985	$ 92.00	$107.00	1997	$ 146.00	$ 172.00
1986	$ 96.00	$112.00	1998	$ 150.00	$ 177.00
1987	$100.00	$117.00	1999	$ 154.00	$ 182.00
1988	$103.00	$121.00	2000	$ 159.00	$ 188.00

2. The reasonableness limit on appraised value per square foot set for NFs from 2001 and thereafter shall be incremented annually by multiplying by an index factor, which is the average of percentages derived from:

i. The Marshall Swift Valuation Index for the Eastern District;

published by Marshall and Swift, 1617 Beverly Blvd., PO Box 26307, Los Angeles, California; and

ii. The weighted average of the Consumer Price Index and, the average hourly earnings of factory production workers published by the New Jersey State Department of Labor.

3. For significant additions to existing NFs beginning operation since January 1, 1978, the reasonableness limit shall be at the original reasonableness limit as determined from (d)1 above, increased by a factor as specified at (d)2 above. A single weighted reasonableness limit for the entire NF will be calculated based upon the square footage and the corresponding year specific index factors of the building as originally appraised and the appraised addition(s).

4. A separate reasonableness limit will be developed for governmental NFs by the same method.

(e) The reasonable limits as described above will be combined to allow for square feet in excess of that established limit where value per square foot is less than that limit for each class of long term care facility.

(f) The CFA for buildings and fixed equipment will be determined by applying the appropriate interest or amortization rate, described in (f)1 and 2 below, to the reasonable appraised value of the building and fixed equipment.

1. Interest rate:

i. For NFs beginning operation before January 1, 1978, the interest rate is equal to the Medicare return on equity rate for the 12 month period ending with December of 1976 (10.719 percent).

ii. For NFs, or significant additions to existing NFs, beginning operation between January 1, 1978 and September 30, 1985, the interest rate is equal to the Medicare return on equity rate published at the inception of operations.

iii. For NFs, or significant additions to existing NFs, beginning operations between October 1, 1985 and September 30, 1993, the interest rate is equal to 150 percent of the Medicare return on equity rate published at the inception of operations.

iv. For NFs, or significant additions to existing NFs beginning operations on or after October 1, 1993, the interest rate is equal to 150 percent of the applicable interest rate at the inception of operations as indicated by the Table of Average

Interest Rates on Special Issues of Public-Debt Obligations Issued to the Federal Hospital Insurance Trust Fund as published by the Office of the Actuary of the Federal Health Care Financing Administration.

2. The amortization rate shall be equal to the ratio of annual debt service (principal and interest) to original principal required to amortize a loan in 25 equal installments, with an interest rate equal to the appropriate above defined "interest rate".

(g) For the first 25 years of the life of a NF beginning with the year of construction, the amortization rate will be applied to the reasonable appraised value of the building and fixed equipment:

(h) Beyond the 25th year after construction, the interest rate will be applied to the reasonable appraised value of buildings and fixed equipment.

(i) For NFs built-in multiple stages, a weighted average year of original construction will be established by weighing licensed beds by the age of the component multiple stages of the building in which the beds are located. Where inequities could result from this calculation, homes with suitable records may request that the weighted average year of construction be calculated based upon plant square feet constructed.

(j) For NFs with residential and/or sheltered care patients, data relative to common areas will be apportioned to nursing patients based upon base period licensed beds. After making such apportionments, appraised values will be subject to the reasonableness screens described in (c), (d) and (e) above and, where applicable, to the weighted average year of construction calculations described in (i) above. This proration will not be redetermined for subsequent years in the absence of significant changes in facilities or in patient mix.

(k) For NFs that were converted to NF use from other uses, the year of conversion will be used provided the conversion costs exceeded the acquisition cost of the building and building equipment. Otherwise, the original year of construction will be used.

(l) For existing NFs the State will not increase the CFA rate in future years should the Table of Average Interest Rates on Special Issues of Public-Debt Obligations issued to the Federal Hospital Insurance Trust Fund as published by the Office of the Actuary of the Federal Health Care Financing Administration increase.

(m) The departments will review, on an individual basis, situations where the strict application of the provisions of this section would be inappropriate under particular circumstances, such as:

1. Situation where an existing debt must be refinanced in connection with obtaining funds to expand existing NFs;

2. The inability of NFs to obtain 25-year financing.

10:63-3.12 Land

(a) The CFA for land will be based upon appraised value of land and land improvements determined by an agent designated by the State of New Jersey as follows:

1. For NFs beginning operation before January 1, 1978, the 1977 value of land and land improvements;

2. For NFs beginning operation on or after January 1, 1978, the value of land and land improvements as of the completion of construction;

3. For additions to existing NFs beginning operation on or after January 1, 1978, the value of additional land acquired or additional land improvements made as of the completion of construction of the addition. Land or land improvements previously included in a facility's appraisal will not be reappraised in determining value of an addition to a facility;

4. For replacement facilities beginning operation on or after January 1, 1978, the value of additional land acquired or additional land improvements made as of the completion of construction. Land or land improvement included in the original facilities appraisal will not be reappraised in determining value of a replacement facility;

5. Land and land improvement value will be subject to reasonable limits with respect to:

    i. Reasonable land area;

    ii. The total reasonable appraised value of reasonable land area.

6. The Department shall establish a reasonableness limit on the amount of reimbursement that an NF shall receive for the land component of its CFA. Reasonableness limits for land and land improvements will be the same as defined for property taxes on land at N.J.A.C. 10:63-3.7.

    i. The reasonableness limits on the appraised value of land set for NFs from 1977 through 2000 are as follows:

Year	Percentage Factor	Acreage Factor	Year	Percentage Factor	Acreage Factor
1977	140.00	2/5	1989	238.29	2/5
1978	155.00	2/5	1990	242.94	2/5
1979	165.00	2/5	1991	246.94	2/5
1980	175.00	2/5	1992	250.65	2/5
1981	185.00	2/5	1993	254.62	2/5
1982	195.00	2/5	1994	258.73	2/5
1983	205.00	2/5	1995	262.42	2/5
1984	215.00	2/5	1996	266.01	2/5
1985	220.65	2/5	1997	268.29	2/5
1986	225.25	2/5	1998	271.18	2/5
1987	229.35	2/5	1999	274.05	2/5
1988	232.75	2/5	2000	277.10	2/5
		urban/rural			urban/rural

ii. The reasonableness limit for appraised value of land set for NFs from 2001 and thereafter shall be incremented annually by adding an index factor, which is the average of percentages derived from:

(1) The Marshall Swift Valuation Index for the Eastern District; published by Marshall and Swift, 1617 Beverly Blvd., PO Box 26307, Los Angeles, California; and

(2) The weighted average of the Consumer Price Index and the average hourly earnings of factory production workers published by the New Jersey State Department of Labor.

iii. For acquisitions of land related to addition(s) to building or building replacements (see N.J.A.C. 10:63-1.2 for definition of "replacement nursing facility"), a single weighted reasonableness limit for the entire NF land evaluation shall be calculated based upon acreage and the appraisal land limit factors of land as originally appraised and the land-appraised addition(s) to land.

(b) The applicable interest rate developed for a facility per N.J.A.C. 10:63-3.11(f) will be applied to the reasonable appraised land value.

(c) The provisions of N.J.A.C. 10:63-3.11(l) and (m) will also apply to CFA for land.

(d) For NFs providing residential or sheltered care, reasonable appraised values for land will be prorated to nursing care residents based upon their

proportion of base period total beds. This proportion will not be redetermined in the absence of significant changes in resident mix.

10:63-3.13 Moveable equipment

(a) The moveable equipment allowance will be based upon the median requirements per bed at 1977 price levels. This median will be determined by:

1. Selecting new NFs built since 1969 which had over 20 percent Medicaid days in the base period.
2. Incrementing their original expenditures for moveable equipment to 1977 price levels by applying an appropriate index of inflation in equipment costs.
3. Converting these inflated expenditures to cost per bed and ranking Statewide.

(b) The allowance per licensed bed will be determined by applying to this median cost the applicable interest rate developed per N.J.A.C. 10:63-3.11(f).

(c) Inasmuch as this allowance will be based upon the current replacement cost of new equipment, it will be deemed to provide for unusually large expenditures for maintaining old equipment (the departments consider it to be purely a management prerogative as to when to replace, rather than repair, old equipment). A provision for ongoing routine equipment maintenance and replacements will be included in the maintenance and replacements allowance as described in N.J.A.C. 10:63-3.14.

10:63-3.14 Maintenance and replacements

(a) An allowance for the maintenance of land, land improvements, building and equipment and for replacement of equipment will be developed for Class I and Class II facilities and each type of Class III facility as follows:

1. Expenditures for this purpose in the base period for Class I, Class II and each type of Class III of NF which had over 20 percent Medicaid days in the base period will be adjusted to price levels at the midpoint of the base period through the application of the inflation factor to reported costs for fiscal years ending prior to December. Class III NFs will not be excluded due to percentage of Medicaid days.
2. Homes which were substantially expanded or remodernized during this period will be excluded from calculations described in (a)3 below.

3. For the remaining NFs, maintenance and replacement costs per plant square foot at base period price levels will be calculated for each class of NF. Mathematical techniques will be used to determine a general formula describing the relationships between expenditures per plant square foot for maintenance and replacements and factors such as age of buildings, estimated building replacement costs, and so forth.

4. The 15 percent highest and 15 percent lowest extremes in actual expenditures compared with this general formula will then be removed from further calculations, except for Class III NFs. The same mathematical techniques will then be applied to the remaining 70 percent of the data to develop the formula to be used to calculate a reasonable allowance for each class of NF for maintenance and replacement.

5. Seventy percent of the costs of leasing equipment will be recognized as "maintenance and replacement" costs.

6. Each NF's maximum total allowance per reasonable plant square foot for any one year will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. 10:63-3.7(a)1, 2 and 3.

   i. For Class III NFs which are approved as a combination of Ventilator/Respirator type and some other SCNF type listed at N.J.A.C. 10:63-3.3(a)3ii, the reasonable limit for maintenance and replacements will be determined by multiplying the current costs of maintenance and replacement attributable to each type of SCNF patient times the respective cost per square foot maintenance and replacement cost limits. The products will be totaled, and then divided by the total current cost of maintenance and replacement expenses. The resulting combined cost limit will then be multiplied by the reasonable long term care square feet of the SCNF to determine the maintenance and replacement screen.

	(1)	(2)	(3)
		Limit	Total
	Cost	Per square foot	(1) x (2)
Vent	A	C	E
Other	B	D	F
Total	G		H

Weighted limit per square foot=H/G.
Total reasonable limit=Weighted limit x Square feet

7. Base period expenditures in excess of this minimum allowance may be carried forward and applied in future years in which expenditures are below their respective maximum allowance.

   i. Actual expenditures that are below the limits for the base period, may be carried and applied to excess expenditures in subsequent years. The following example illustrates how two typical NFs would be affected. Savings are indicated in parentheses, for example, (20.00) means a savings of $20.00

Year No. I	**NF A**	**NF B**
Actual expenditures	$130.00	$ 80.00
Limit	100.00	100.00
Excess (savings) carried forward	30.00	(20.00)
Year No. 2 NF A	Example 1	Example 2
Actual expenditures	$ 60.00	$ 85.00
Carried forward	+30.00	+30.00
Total eligible	90.00*	$115.00
Limit	105.00	$105.00
Carried forward to Year No. 3	$(15.00)	$ 10.00
Year No. 2 NF B	Example I	Example 2
Actual expenditures	$120.00	$130.00
Limit	$105.00	$105.00
	NF A	NF 13
Plus carried forward	+20.00	+20.00
Revised limit	$125.00	$125.00
Carried forward to Year No. 3	$ (5.00)	$ 5.00
* Included in rates		

8. Expenditures for replacements, capitalized maintenance and leases will be prorated to nursing patients, based upon the ratio of nursing square feet (including a prorated share of common areas) to total plant square feet.

10:63-3.15 Property insurance

(a) An allowance for property insurance will be developed for each home as follows:

1. Base period property insurance costs per dollar of appraised value

and per dollar of 1977 replacement costs will be calculated for all Class I NFs. Separate calculations will be made for Class II facilities and each type of Class III facility.

2. Mathematical techniques will be applied to this data to develop formulas describing the normal relationships between property insurance costs and appraised values and estimated replacement costs. Separate formulas will be developed for urban and non urban NFs.

3. The procedures described in N.J.A.C. 10:63-3.14 will be used to eliminate extremes and to develop the formula to be used to calculate the reasonableness limit for property insurance, except for the calculation of Class III limits.

4. Each NF's reasonableness limit per reasonable plant square foot will be developed by applying this formula to its particular factors and incrementing the result by 10 percent. No allowance will be provided for plant square feet considered unreasonable per N.J.A.C. 10:63-3.7(a)1 and 2.

10:63-3.16 Target occupancy levels

(a) A target occupancy level of 95 percent of licensed bed-days (excluding quiet beds) will be used to develop the reasonable per diem amounts of the following rate components:

1. Property taxes;

2. Utilities;

3. Special amortization;

4. CFA for:

   i. Buildings and building equipment;

   ii. Land and land improvements;

   iii. Moveable equipment;

   iv. Maintenance and replacements;.

   v. Property insurance; and

5. Actual NF expenses for depreciation, rental, interest, and amortization in accordance with N.J.A.C.10:63-3.10(c).

(b) For Class III NFs, if the base period Medicaid occupancy is 80 percent or greater, the target occupancy for the rate components in (a) above will be 90 percent.

(c) For rates implemented on or after July 1, 2000, target occupancy shall be calculated as follows:

1. For those nursing facilities that are at or above 90 percent occupancy, the reasonable base period costs shall be divided by actual base period patient days.

2. For those nursing facilities that are above 85 percent but below 90 percent as documented in the NF cost report, a review of the previous year's occupancy shall determine which of the two following options shall be used:

   i. If the previous year's occupancy is at or above 90 percent, the reasonable base period costs shall be divided by actual base period patient days.

   ii. If the previous year's occupancy is also less than 90 percent, the reasonable base period costs shall be divided by 90 percent of licensed bed days.

3. For those nursing facilities that are below 85 percent occupancy, the reasonable base period costs shall be divided by 90 percent of licensed bed days.

4. Actual base period patient days shall include paid bed hold days.

(d) For new Class I and Class II facilities an occupancy rate of 80 percent will be used for provisional rates during the first year of operation subject to retroactive adjustments to actual occupancy should it exceed 80 percent (but no higher than 95 percent will be used).

(e) For new Class III NFs, an occupancy rate of 80 percent will be used for provisional rates during the first year of operation. The retroactive adjustment from an interim to an actual rate for the first year of operation shall use actual occupancy should it exceed 80 percent (but no higher than 95 or 90 percent will be used, as determined by (a) or (b) above).

(f) If base period patient days exceed licensed bed days calculated per (a) above, then the target occupancy will be entered at 95 percent of actual base period patient days.

10:63-3.17 Restricted funds

(a) Where donor restricted funds have been expended for operating purposes and, accordingly have been reported as an expense recovery/elimination, the availability and use of such funds will not be taken into account in establishing rates to the extent that they produce actual unit costs below the median unit

costs and NF's developed for determining reasonableness. (It should be noted that the availability or use of such funds will not be taken into account at all with respect to CFA calculations.)

(b) The intent of this provision is to exclude, in screening, expenditures made from donor-restricted funds, but not to "appropriate" such funds where they result in net costs below the median.

10:63-3.18 Adjustments to base period data

(a) As described elsewhere in this subchapter, with the exception of capital items, rates will be based upon reasonable actual base period costs. This section provides for adjustments to reasonable base period costs in establishing prospective rates.

1. Appropriate adjustments will be made to reasonable base period costs for the effect of changes between the base period and the prospective rate period in:
    i. State or Federal standards of care;
    ii. Definitions of "routine patient care services" reimbursable in Medicaid per diems;
    iii. Limitations on total or per diem amounts of special patient care services reimbursable in Medicaid per diems.
2. NFs may also request that cost in addition to base period expenditures be included in the prospective rates owing to:
    i. Actions mandated by governmental authorities and/or approved by same in the certificate of need process ("legal" changes):
    ii. Desires to increase the quality of care above that attainable at base period cost levels ("management" changes).
    iii. Appointment of a special medical guardian required to authorize emergency medical treatment for a patient.
    iv. Emergency evacuation of a facility which was conducted consistent with an Emergency Management Evacuation Procedure which has been duly adopted and fully implemented by the facility. Costs in additions to base period expenditures for emergency evacuation shall be only those extraordinary costs which are directly related to evacuation, and routine costs which exceed base period levels as a direct result of the emergency evacuation.
3. With respect to requests for management changes, the

departments will take the position that it is not a prerogative of a rate setting body to unilaterally make or amend social policies, especially with respect to the appropriateness of current allocations of State resources to the care of indigent NF patients. Accordingly, in the absence of other compelling reasons, management changes will be approved only in areas where quality has been found to be marginal by health facility inspection and actual costs are commensurately low.

4. Where legal and management changes have been approved and the approved costs are not expended in the prospective rate period, the unspent amount will be recovered from the NF.

5. In the case of significant items, the departments may exclude the effects of legal and management changes from rates until the change is effected, and if necessary, new appraisals made.

10:63-3.19 Inflation

(a) A provision will be added to reasonable base period costs to provide for inflation/deflation between the base period and the prospective rate period. Changes in two factors will be used to develop this provision.

1. Average hourly earnings of manufacturing employee in New Jersey as published by the Bureau of Labor Statistics (weighted 60 percent);

2. The (consumer price index) Consumer Price Index as published by the Bureau of Labor Statistics (weighted 40 percent).

(b) This inflation factor will be developed by the Division of Medical Assistance and Health Services and the Department of Health, Health Facilities Rate Setting.

(c) Should the economic factor as developed for hospitals include a provision for changes in legally mandated fringe benefits, a similar provision will be included in prospective nursing NF rates.

(d) If, for reasons beyond the control of a NF, rates have not been redetermined within three months after receipt of its reports, an interim adjustment for inflation may be made to existing rates for cash flow purposes. The inflation increment would be based upon the number of months from the midpoint of the current rate period to the beginning point of the new rate period. The interim rate will be subject to a retroactive adjustment to the beginning of the prospective rate period upon determination of the approved rate via the methodology described in these guidelines.

(e) NFs may also request interim adjustments to rates during a prospective rate period for either legally mandated matters or for extraordinary factors beyond their control. Such adjustments, if approved, would not apply retroactively unless, for reasons beyond the control of the NF, costs are affected retroactively.

(f) No provision for inflation will be made with respect to costs for buildings, land, moveable equipment, interest and lease, as determined by N.J.A.C. 10:63-3.11, 3.12 and 3.13 nor to special amortization of capital costs as determined by N.J.A.C. 10:63-3.8.

10:63-3.20 Total rates

Rates shall not contain allowances for working capital or for an incentive for NF's participating in a cooperative buying group.

10:63-3.21 Appeals process

(a) When a NF believes that, owing to an unusual situation, the application of these rules results in an inequity (except for the application of N.J.A.C. 10:63-3.2(f)), two levels of appeals are available: a Level I Appeal heard by representatives from the Department of Health and Department of Human Services; and a Level II Appeal heard before an Administrative Law Judge.

1. Level I Appeal: A request for a Level I appeal should be submitted in writing to the Department of Health, Health Facilities Rate Setting, Health and Agriculture Building, Room 600, John Fitch Plaza, CN-360, Trenton, New Jersey, 08625.

    i. Requests for Level I appeals shall be submitted in writing within 20 calendar days of receipt of notification of the rate by the facility.

    ii. A facility shall identify its rate appeal issues in writing to the Department of Health, Facilities Rate Setting, within 50 calendar days of receipt of notification of the rate by the facility.

    iii. Documentation supporting the appealed rate issues shall be submitted to the Department of Health, Facilities Rate Setting, within 80 calendar days of receipt of notification of the rate by the facility.

    iv. The first level of appeal will be heard by analysts from the Department of Health and supervisory-level representatives from both the Department of Health and the Department of Human Services, as required. NFs should be prepared to provide such substantiating material as may be required for an informal discussion of the subject matter.

v. Level I appeals will endeavor to reach equitable resolutions of matters peculiar to individual NFs. They will not be expected to resolve items which have policy implications or broad applicability.

vi. The analyst's recommended resolutions will first be reviewed at appropriate levels within the Department of Health, Health Facilities Rate Setting, and will then be forwarded to the Division of Medical Assistance and Health Services for the approval, of the Director or a designee of the Director.

vii. Adjustments resulting from the Level I appeal shall be effective as follows:

(1) At the beginning of the prospective reimbursement period if an error in computation was made by the Department or if the appeal was submitted within the specified period.

(2) On the first of the month following the date of appeal for non-computational matters if the appeal is submitted after the specified period.

viii. The date of submission shall be defined as the date received by the Department of Health.

2. Level II Appeal (Administrative Law Appeal): If the NF is not satisfied with the results of the Level I Appeal, it may request a hearing before an Administrative Law Judge.

i. Request for an administrative hearing must be submitted in writing to the New Jersey State Department of Health, Health Facilities Rate Setting, Health and Agriculture Building, Room 600, John Fitch Plaza, CN 360, Trenton, New Jersey 08625.

ii. In accordance with N.J.A.C. 10:49-5.3(a), requests for an Administrative hearing will be considered timely filed if they are submitted within 20 days from the mailing of the ruling in the Level I appeal.

iii. The Administrative hearing will be scheduled by the Office of Administrative Law and the facility will be notified accordingly.

iv. At the Administrative hearing the burden is upon the NF to demonstrate entitlement to cost adjustments under CARE Guidelines (Cost Accounting and Rate Evaluation System). A complete set of CARE Guidelines may be obtained from: New Jersey State Department of Health, Health Facilities Rate Setting, Health and Agriculture Building, Room 600,

John Fitch Plaza, CN 360, Trenton, New Jersey 08625.

10:63-3.22 Transitional relief for salary region adjustment; State Fiscal Year 1993

(a) In order to provide transitional relief for those nursing facilities most negatively impacted by the adjustment to a single Statewide salary region which began July 1, 1992, a rate adjustment shall be made for qualifying facilities. Nursing facilities which incurred reductions in Medicaid reimbursement in excess of $55,000 for services provided to Medicaid recipients during State fiscal year 1993 (July 1, 1992 to June 30, 1993), as a result of the implementation of the single Statewide salary region, shall receive a prospective per diem rate adjustment.

(b) Facilities shall be reimbursed 25 percent of the annual reduction of Medicaid reimbursement in excess of $55,000. This amount represents the reduction of Medicaid reimbursement in excess of $55,000 for the period from April 1, 1993 to June 30, 1993. The per diem add-on shall be calculated for each facility as follows:

1. Determine for each facility the prospective or interim to actual per diem rate(s) for the period from July 1, 1992 to June 30, 1993 using the salary region system effective prior to July 1, 1992;
    i. These calculations shall not include the "six month" acuity adjustment of rates for patient mix;
2. Determine the difference between the corresponding single salary region per diem reimbursement rate(s) for the period from July 1, 1992 to June 30, 1993 (excluding the acuity adjustment of rates) and the per diem rate(s) as calculated in (b)1 above;
3. Multiply the per diem rate difference(s) from (b)2 above by the number of the facility's Medicaid patient days paid (allocated to the applicable rate periods if appropriate) for the period from July 1, 1992 to June 30, 1993.
4. From the sum determined in (b)3 above deduct the amount of $55,000; and
5. Divide the remainder from (b)4 above by four; and
6. Divide the quotient from (b)5 above by the total number of the facility’s Medicaid patient days paid for the period from April 1, 1993 to June 30, 1993.

(c) The resulting per diem amount shall be paid as an add-on to each eligible facility's routine prospective rate for a three month period commencing July 1,

1993.

10:63-3.23 Transitional relief for salary region adjustment; State Fiscal Year 1994

(a) In order to provide transitional relief for those nursing facilities most negatively impacted by the adjustment to a single Statewide salary region which began July 1, 1992, a rate adjustment shall be made for qualifying facilities. Nursing facilities which incurred reductions in Medicaid reimbursement in excess of $55,000 for services provided to Medicaid recipients during State fiscal year 1994 (July 1, 1993 to June 30, 1994), as a result of the implementation of the single Statewide salary region, shall receive a per diem rate adjustment.

(b) Facilities shall be reimbursed the annual reduction of Medicaid reimbursement in excess of $55,000 for the period effective July 1, 1993 to June 30, 1994. The per diem addon shall be calculated for each facility as follows:

1. Determine for each facility the prospective or interim to actual per diem rate(s) for the period from July 1, 1993 to June 30, 1994 using the salary region system effective prior to July 1, 1992;

    i. These calculations shall not include the "six month" acuity adjustment of rates for patient mix;

2. Determine the difference between the corresponding single salary region per diem reimbursement rate(s) for the period from July 1, 1993 to June 30, 1994 (excluding the acuity adjustment of rates) and the per diem rate as calculated in (b)1 above;

3. Multiply the per diem rate difference(s) from (b)2 above by the number of the facility's Medicaid patient days paid (allocated to the applicable rate periods if appropriate) for the period from July 1, 1992 to June 30, 1993;

4. From the sum determined in (b)3 above deduct the amount of $55,000;

5. Divide the remainder from (b)4 above by the total number of the facility's Medicaid patient days paid for the period from July 1, 1992 to June 30, 1993.

(c) The resulting per diem amount shall be paid as an add-on to each eliglbe facility's routine prospective rate for a 12-month period commencing July 1, 1993.

10:63-3.24 Transitional relief for salary region adjustment; State Fiscal Year 1995

(a) In order to provide transitional relief for those nursing facilities most

negatively impacted by the adjustment to a single statewide salary region which began July 1, 1992, a rate adjustment will be made for qualifying facilities. Nursing facilities which are expected to incur reductions in Medicaid reimbursement in excess of $27,500 for services to be provided to Medicaid recipients for the period July 1, 1994 to December 31, 1994, as a result of the implementation of the single statewide salary region, will receive a prospective per diem rate adjustment.

(b) Facilities will be reimbursed the six-month reduction of Medicaid reimbursement in excess of $27,500 for the period effective July 1, 1994 to December 31, 1994. The per diem add-on will be calculated for each facility as follows:

1. Determine for each facility the prospective or interim to actual per diem rate(s) for the period from July 1, 1994 to December 31, 1994 using the salary region system effective prior to July 1, 1992;

    i. These calculations will not include the (six month) acuity adjustment of rates for patient mix.

2. Determine the difference between the corresponding single salary region per diem reimbursement rate(s) for the period from July 1, 1994 to December 31, 1994 (excluding the acuity adjustment of rates) and the per diem rate as calculated in (1) above;

3. Multiply the per diem rate difference(s) from (b)2 above by the number of the facility's Medicaid patient days paid (allocated to the applicable rate periods if appropriate) for the period from July 1, 1993 to December 31, 1993;

4. From the product determined in (b)3 above deduct the amount of $27,500;

5. Divide the remainder from (b)4 above by the total number of the facility's Medicaid patient days paid for the period from July 1, 1993 to December 31, 1993;

6. Multiply the quotient by six;

7. Divide the product by five.

(c) The resulting per diem amount will be as an add-on to each eligible facility's routine prospect rate for a five month period commencing August 1, 1994.

10:63-3.25 Transfer of ownership

(a) The following applies to the transfer of ownership of a nursing facility, as defined in N.J.A.C. 10:63-1.2:

1. For any facility that transfers ownership, the new owner shall receive a provisional per diem rate for the first year of operation based on the previous owner's per diem rate. After the first full year of operation, a new rate or rates based on actual costs incurred by the facility shall be calculated from the transfer of ownership date through the first prospective rate period.

2. For any facility that transfers ownership, the maintenance and replacement carryunder or carryover shall not be applicable to the new owner. After a first year of actual costs are incurred by the new owner, a maintenance and replacement carryunder or carryover shall be calculated based on N.J.A.C. 10:63-3.14(a)7i.

SUBCHAPTER 4 AUDIT

10:63-4.1 Audit cycle

(a) Any cost study submitted by a Medicaid participating nursing facility (NF) which is selected for audit on or after February 7, 1983 may be audited within three years of the due date of the cost report or the date it is filed, whichever is later. This requirement shall be satisfied if the on-site audit of the NF is initiated within the three-year period and completed within a reasonable time thereafter. If a NF audit is not initiated within this time limit, the appropriate cost study or cost studies shall be excluded from the audit, subject to the conditions set forth in the balance of this subsection and the waiver provisions set forth in (b) below. Exclusion is subject to the following conditions:

1. Failure to initiate a timely audit shall not preclude the Division from collecting overpayments, interest or other penalties if the overpayments are identified by an agency other than the Division.
2. When a timely audit is conducted and additional overpayments are discovered by another agency, the Division shall not be precluded from collecting such overpayments together with any applicable interest or other penalties.

(b) The Division shall not be precluded from waiving the three-year limitation for good cause, and good cause shall include, but not be limited to, the following circumstances:

1. The overpayments involved in the audit were generated as a result of fraudulent activity by the NF or NF related party, whether or not that fraudulent activity has been the subject of a criminal investigation and/or prosecution;
2. The NF, its agents or employees have failed to cooperate in the initiation or conduct of the audit;
3. The Division could not have reasonably discovered by audit any evidence of the overpayment within the three-year period;
4. The audit could not be initiated within the three-year period because of delay or cessation of the audit resulting from a request by a law enforcement agency or an administrative agency with jurisdiction over the facility.
    i. This provision shall not apply if the NF's records are available and no request for delay or cessation of the audit has been made by any of these agencies.

(c) Notice must be given to the NF when the three year requirement is waived together with the reasons for such action. The NF may request a hearing on any waiver by the Division to the extent authorized by applicable statutes, rules, and regulations.

10:63-4.2 Audits

(a) For the exclusive purpose of calculating interest, uner N.J.S.A. 30:4D-17(f), "completion of the field audit" for nursing facility providers shall be defined in the following manner:

1. For all such audits and audit recovery cases pending on February 7, 1983, it shall mean the date that field work is completed, or the date information requested from the provider during the course of that field work is received, whichever is later;

2. For all such audits and audit recovery cases pending on March 1, 1983, which are, have been or will be referred either to the Legal Action Committee, or to the Division of Criminal Justice or other agency for criminal investigation, it shall mean the date the Office of Program Integrity Administration (OPIA) receives authorization to take administrative action.

3. For all such audits initiated on or after February 7, 1983, it shall mean the date the exit conference is completed or the date information requested from the provider during the course of the exit conference is received, whichever is later.

(b) Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires additional field work, for the exclusive purpose of calculating interest under N.J.S.A. 30:4D-17, the field audit shall be considered completed when the additional field work is completed.

(c) Notwithstanding any of the previous subsections, if after the screening of any nursing facility provider audit the Assistant Director, OPIA, determines with reasonable justification that an act or omission on the part of the provider requires that additional information or documentation be obtained from the provider, then a completed field audit shall, for the exclusive purpose of calculating interest, be considered reopened and interest shall again accrue for the period beginning 20 days from the date that the request for such information or documentation is received by the provider and ending on the date that all of the requested information or documentation is received by the agency making the request.

(d) Notwithstanding any of the previous subsections, if all or part of any

nursing facility provider audit initiated on or after the effective date of this subsection is referred to the Division of Criminal Justice or other agency for criminal investigation:

1. In the event no criminal action results from the referral the field audit shall be considered completed one year from the date the decision was made to refer the matter for criminal investigation;
2. In the event criminal action does result from the referral, the field audit shall be considered completed on the date OPIA receives authorization to take administrative action.

10:63-4.3 Final audited rate calculation

(a) The Division of Medical Assistance and Health Services will calculate final per diem rates based on audit adjustment reports.

(b) The final per diem rates determined based on (a) above cannot exceed the prospective rates previously paid.

(c) Settlement after final rate calculation will be for fraud and/or abuse collections or recoveries of payments when the final rate is lower than the original rate.

(d) The basis for establishing guidelines for the prospective per diem rates, and costs which may be reported, are the CARE (Cost Accounting and Rate Evaluation System) Guidelines which appear at N.J.A.C. 10:63-3.

(e) This section applies to all current, pending or future audits for rate years on or after March 20, 1995.